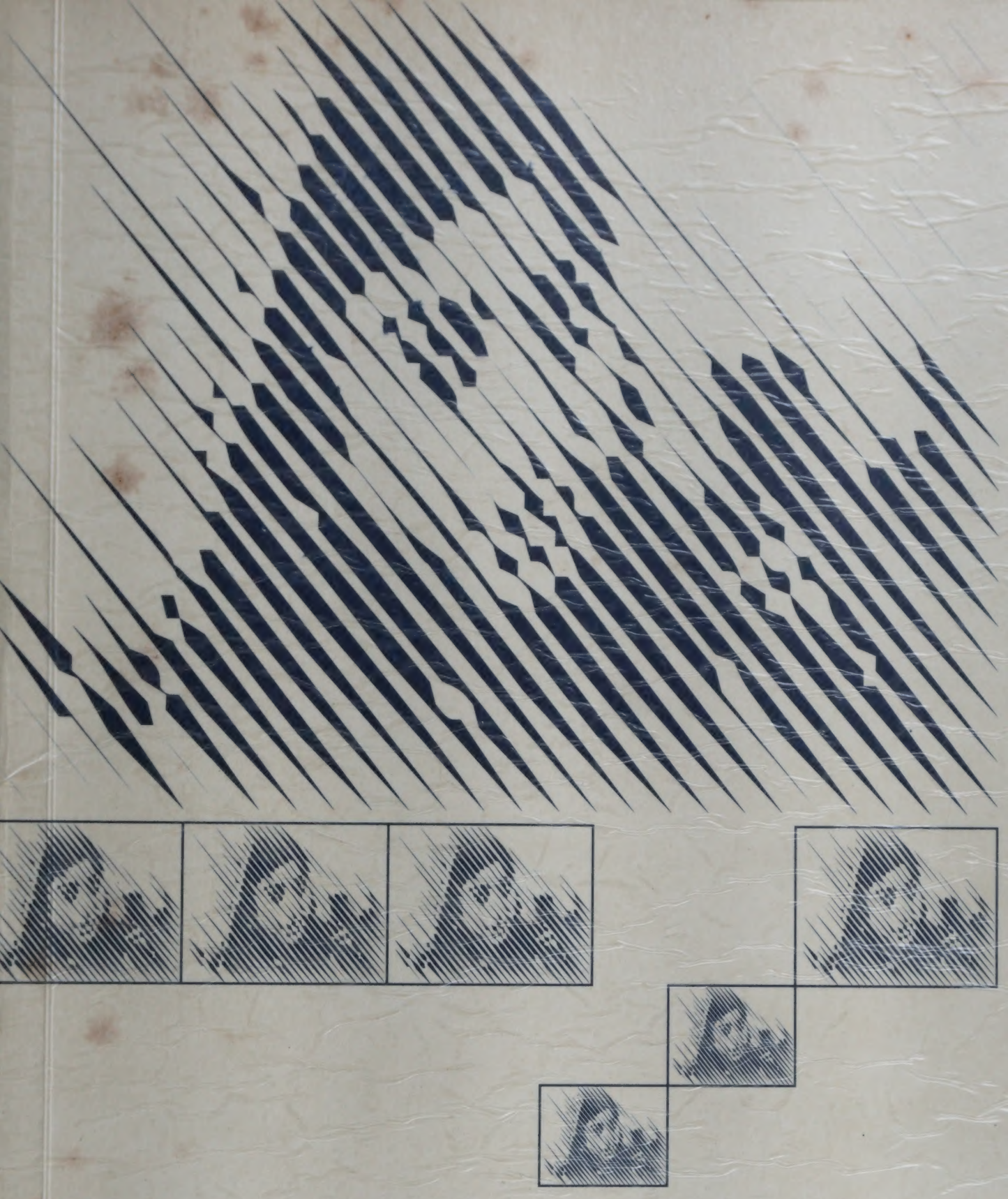

Adolescent Needs

Implication for programmes

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Need Assessment of Adolescents in Uttar Pradesh and Rajasthan States of India

A Report

Edite

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Foreword

Globally, the largest share of adolescents and young people is and will continue to be in Asia (UNFPA 1998). In Asia, India is a country with an adolescent population of 200 million and overall youth (10-24 years) of around 300 million. Yet, these groups with its special needs are not covered by any programs. Our health programs start after an individual is married and ends its outreach for all practical purpose by the time the child is five years. Although adolescence being a crucial phase of life, very little data is available to explain the special physiological, psychological and emotional needs. Lack of information and data about the needs mean that service providers are ill equipped to deal with these groups. There is some information about the married adolescents but very less is known about the unmarried ones. Researchers have only recently begun investigating adolescent sexuality in depth and their study findings may be partial.

In our socio-cultural context, community failure to address the adolescent related issues further complicates the situation. Different types of barriers may hinder the provision of health care services to the youths as well as their utilization. Also, we have very little ground experience for such activities and programs. Since the ICPD and the Beijing conference on women, there have been initiatives from the government to bring to the fore young people's reproductive and sexual health as an issue, but notable still is the absence of a clear policy.

It is well known that the needs of adolescent boys and girls vary with their socio-cultural context. Very few studies are available in the country, which can be cited as a reference in this area. Having realised that adolescent needs are special requiring special interventions, it is only natural to identify these needs as a first step to initiate the program. This study therefore aims at assessing the needs of adolescent boys and girls in the age range of 10-19 years in the rural areas of two districts (Mirzapur and Varanasi) of Uttar Pradesh and two districts (Jodhpur and Jaipur) of Rajasthan.

The John D. and Catherine T. MacArthur Foundation, Chicago, USA supported this study as part of a larger project on capacity building of NGOs by MAMTA to work with adolescents. The purpose of the input is to undertake activities and programmes with a view to optimise the health needs of adolescents, the target population being the rural boys and girls in this phase of development. The states of Uttar Pradesh and Rajasthan were the two states selected for the purpose where very few such interventions have been taken up and the need felt was acute. Moreover, these two states have been found to be poor performers in terms of woman and child survival rates (high IMR and MMR). Adolescent population in rural areas was targeted for the reason that these areas have so far been neglected. The limited focussed Adolescent Reproductive and Sexual Health (ARSH) intervention in place, are mostly restricted to urban settings although 78 percent of the country's total population in the 10 - 19 years age group live in the rural areas as per the population estimates of 1993 (Department of Youth Affairs, 1996).

MAMTA with a vision and experience of working towards ensuring an environment for optimum health and development for young people conducted Adolescent Need Assessment during June to August 1999. The entire phase of planning and implementation of the study also actively involved the partner NGOs and strengthened their capacities to conduct participatory research on adolescents in their areas.

Abbreviations and Acronyms

AAK	*Arthik Anusandhan Kendra*
AIDS	Acquired Immuno Deficiency Syndrome
ANM	Auxiliary Nurse Midwife
ARH	Adolescent Reproductive Health
ARHD	Adolescent Reproductive Health and Development
ARSH	Adolescent Reproductive and Sexual Health
CHC	Community Health Centre
CRY	Child Relief and You
DRDA	District Rural Development Agency
EDP	Entrepreneurship Development Programme
GOI	Government of India
HIV	Human Immunodeficiency Virus
HRD	Human Resource Development
ICDS	Integrated Child Development Service
ICMR	Indian Council of Medical Research
ICPD	International Conference on Population and Development
IIPS	International Institute of Population Studies
IMR	Infant Mortality Rate
LHV	Lady Health Visitor
MCH	Maternal and Child Health
MMR	Maternal Mortality Rate
NFE	Non Formal Education
NFHS	National Family Health Survey, 1992 - 93
NGO	Non Government Organisation
PHC	Primary Health Centre
PRA	Participatory Rural Appraisal
RCH	Reproductive and Child Health
RDA	Recommended Dietary Allowance
RMP	Registered Medical Practitioner
RTI	Reproductive Tract Infection
SAARC	South Asian Association for Regional Cooperation
SCs	Scheduled Castes
SC	Sub Centre
SERVE	Society for Education, Research and Voluntary Efforts
SIFPSA	State Innovation in Family Planning Service Agency
STs	Scheduled Tribes
STI	Sexually Transmitted Infection
SWI	Social Welfare Institute
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UP	Uttar Pradesh

- Common substance used by boys are chewing and smoking of tobacco, ganja and alcohol in study districts. No addiction was reported among girls in any of the study areas, though it was found in the older women.
- Gender discrimination was reported in all aspects of life, more so in education, food, socialisation, and marriage etc. Parents preferred boys to continue higher education. Group meetings in study areas revealed that girls were perceived as *'other's property'*.
- Girl respondents in most of the study areas listed their priorities as 'freedom from mobility restriction', 'community to understand the importance of education' and 'no early marriage'. However menstruation management did not appear as one of the important needs of the girls.
- Though male respondents ranked basic amenities like 'drinking water facility', 'provision of high school', 'health care facility' as first priority, the need of a counselling centre for 'knowledge on sex and sexuality' were labelled as a close second. Many voiced 'Knowledge on adolescent issues' as crucial.
- During discussion with parents and elders on adolescent needs and concerns, they expressed emotional problems, poor nutritional status and unemployment problems among boys. Mothers of girls expressed their concerns about misconception related to menarche management.
- On enquiry about treatment seeking behaviour, both boys and girls mentioned that options available to them are *Ojhas*, Government Hospitals, quacks and private qualified doctors in order of preference. They would contact qualified doctor in case of emergency or major health problem, though they are very expensive.

The socio-economic profile of the study areas and the needs expressed by respondents reveal the inadequacy of basic services like education and health, particularly in rural areas of Jodhpur and Mirzapur. These findings have to be disseminated to the elders and the gatekeepers of the community to sensitise and facilitate them to develop plans to address the concerns expressed by the adolescents in their area. They could be guided to form linkages for improvement in infrastructural facilities and quality of services in the area. The literacy status of the respondent boys and girls is lower than the desired. Caste based discrimination suggests that addressing "human rights issue" is an important element in all kinds of intervention initiatives. Early marriage of respondent boys and girls and the information obtained from the group discussion indicate that intervention should also focus on the socio-cultural determinants influencing the age at marriage.

The nature of responses on 'changes perceived during adolescence' by the respondent girls suggest an urgent need for creation of enabling environment in the community, so that they can share and express concerns related to their growth and development, as well as sex and sexuality, and seek support whenever required. The existing knowledge and practice of respondent girls regarding menstrual management indicate that intervention is required in this area to reduce the risk of RTIs. The myths, misconceptions and taboos related to menstrual management among girls and the 'nocturnal discharge' among boys have to be addressed through separate sessions.

The inability of parents to identify the role of additional nutrition during adolescence suggests that necessary intervention has to take place in this area.

The existing level of knowledge about contraceptive options calls for dissemination of correct information on various methods and their proper use to all the adolescent boys and girls. The lack of knowledge among respondent boys and girls regarding RTIs/STIs including HIV/AIDS calls for building up awareness and making support services available.

Discussion on health problems reveals the fact that developing comprehensive health packages in the area of reproductive health is an emerging issue. While expressing their emotional needs, 'controls and restrictions' on them has emerged as one of the major concerns for boys and girls, which they say leads to anger, depression and irritability. The findings of the study indicate the requirement of psychosocial support to address the emotional needs of adolescents.

A non-judgmental approach towards adolescent's drug use and support can be considered as an important element to prevent and minimise drug use related harms.

Gender discrimination was reported several times while discussing different issues with boys and girls and separate discussions with parents. This issue should be incorporated as a basic element of an overall intervention design for adolescents.

Although the parents reconfirm similar needs as expressed by boys and girls, they have also accepted their lack of understanding on different adolescent issues and the existence of a communication gap between them and their children. This clearly indicates that disseminating information to the elders of the community, particularly the parents, is an essential task to enable them to understand 'adolescence' and develop skills to communicate with the adolescents to minimise the communication gap. Parents could also be involved in advocating better adolescent friendly services.

While discussing the preferences of health services, it was revealed that *Ojha*s, witchcraft practitioners and quacks are the first line of service providers for majority of boys and girls in the study areas. The services of qualified medical practitioners both in the private and public sectors are availed of in case of acute disease or an emergency. While making an effort to develop adolescent friendly services, all these service providers have to be taken into consideration for sensitisation on adolescent issues and orientation on RTIs/STIs including HIV/AIDS.

Based on the issues identified during the study, it is revealed that there is a challenging task ahead to work with elders in the community and the service providers, like the health care providers, the ICDS workers and the teachers along with the adolescents. They should be sensitised and made aware of the problems expressed by the adolescents.

Above all, the "adolescents" have to be included at all stages of the project design and implementation for the project to be responsive to their needs and for its wider impact.

I: Introduction

Background

The World Health Organisation (WHO) defines "adolescents" as the population in the age group between 10 to 19 years. More than one billion of the six billion people in the world are between the ages of 10-19 years (The State of World's Children 2000, UNICEF). They are living in a world that is rapidly changing, exposing them to new value systems, modern communications, and often unfamiliar and hostile cultures. Four out of five young people live in developing countries (WHO, SEARO, 1997).

Adolescents constitute over one-fifth of the total population in the region (Table 1). They will continue to grow in most countries of the region for the next 30 years due to the population momentum. However many adolescents in the region are deprived of adequate and quality education and opportunities for acquiring marketable skills; they face unemployment and underemployment, violence and exploitation and are vulnerable to the rising incidences of STIs and HIV/AIDS, abortion and malnutrition etc. All these will have adverse implications for their physical, psychological and economic well being in adulthood.

Table 1 – Percentage of adolescents (10-19 years) in the estimated total population by countries in the SAARC region, 1995

Country	Total Population (000's)	Adolescent Population (000's)	Share (%) of the Adolescent Population in the Total
Bangladesh	118,200	30,644	25.9
Bhutan	1,770	388	21.9
India	929,000	193,221	20.8
Maldives	250	60	24.0
Nepal	21,500	4,841	22.5
Pakistan	136,300	29,786	21.9
Sri Lanka	17,900	3,794	21.2
Total	1,224,920	262,734	21.4

Source: UN Population Division, World Population Prospects: 1996, Revision (October 1996)

Adolescence has been regarded as a critical phase of development because of the rapid and far-reaching biological, emotional and social changes that take place during this period. Yet, this realisation is woefully lacking among the community, the health and development service providers, the policy makers and even the adolescents themselves. Marriage, childbearing and at times menarche among adolescent girls mark the start of adulthood in many cultures. In traditional societies, the earlier maturation of girls leads to early marriage. However, in general, the mean age of marriage is rising while the age of puberty in both sexes appears to be falling. This creates a longer period during which sexual relationship may occur (WHO SEARO report, 1998).

Lack of information, socio-cultural beliefs, practices and prejudices expose adolescent boys and girls to grave risks, which have direct implications on their reproductive health and overall development. Poor understanding of the special needs of adolescents further exacerbates the problem. Adolescents are ill informed about their own health, sexuality, physical growth and hormonal changes. What little they know is either incomplete or inaccurate and confusing. Interestingly enough, parents and teachers are reluctant to share the much-needed information (considered of a personal nature). Even the providers of services in this area do not fill this gap.

It must be understood that the lives and needs of adolescents are unique and therefore different from those of adults. Adolescence is a time of mental and psychological adjustment, being no longer a child, but not yet an adult. Adolescents also explore new interests and these influences mould their thinking, ideas and actions; like exploring sexual relationship, use of alcohol, tobacco and substance abuse. Therefore, the support and understanding from family members during this phase is crucial to enable them to meet these challenges (WHO SEARO report, 1998).

At once vulnerable and worldly, adolescents are a particularly heterogeneous group; in some societies,

married or parents themselves; in others, alienated and isolated from the adult world or in need of special protection from sexual exploitation, child labour or recruitment into armed conflicts. In still other societies, they head households because their parents have died of AIDS or as a result of war or violence. In many, they are the primary wage earners (The State of World's Children 2000, UNICEF).

It was only in the late 1980s, however, that the world community formally recognised how seriously the health of young people impacts on the health and development of future generations. With the further realisation that the current and future health of young people depends very much on their own actions, choices and behaviours, the World Health Assembly passed a special resolution in May 1989 to highlight these issues. During November 1989 the United Nation's General Assembly unanimously adopted the Convention on the Rights of the Child (incorporates adolescents up to the age of 18 years). International Conference on Population and Development (ICPD)[1], Cairo, Egypt, in the year 1994, also re-emphasized the special needs of adolescents and recommended the formulation of policies and programmes addressing their specific needs. The initiative taken so far by the governments to address these issues are limited, covering mostly aspects of reproductive health. However, adolescent issues are much broader than reproductive health in which education, employment, empowerment, family formation, etc. all play critical role (Choudhury, R.H., 1998). After the ICPD meeting in Hague, further emphasis has been laid on this forgotten phase of adolescence in developing countries, which have low marriage age and high fertility rates.

Major demographic, socio-economic and reproductive health characteristics defining the situation of adolescents in South-Asian countries form papers presented at the South Asia Conference on Adolescents during July 1998 at New Delhi

- Large and rapidly growing adolescent populations
- Improved level of literacy
- Low level of educational achievement
- Persistence of gender disparity in school enrolment
- High labour force participation and unemployment rates
- Gender disparity in labour force participation rates
- Persistence of early marriage
- Persistence of early childbearing
- High and increasing adolescent fertility
- Shorter birth intervals and unplanned births
- Poor nutrition and unsatisfactory antenatal care
- Higher risk of infant and maternal mortality
- Low use of contraceptives and high unmet demand for family planning
- Inadequate efforts to promote RH and family planning
- Early onset of pre-marital sex and induced abortion
- Lack of information and services
- Lack of protection against sexual abuse and violence
- Large number of missing women
- Lack of policies on adolescents

Source: (UNFPA Conference Report 1999).

[1] Programme of Action adopted at the ICPD, Cairo, September 1994 -

Chapter VII, Reproductive rights and Reproductive Health - Section E, Adolescents:

The objectives are: (a) To address adolescent sexual and reproductive health issues, including unwanted pregnancy, unsafe abortion and sexually transmitted diseases, including HIV/AIDS, through the promotion of responsible and healthy reproductive and sexual behaviour, including voluntary abstinence, the provision of appropriate services and counseling specifically suitable for the age group; (b) To substantially reduce all adolescent pregnancies (Para 7.44).

Chapter VI, Population Growth and Structure - Section B, Children and Youth:

The objectives are (b) To meet special needs of adolescents and youth, especially young women, with due regard for their own creative capabilities, for social, family and community support, employment opportunities, participation in the political process, and access to education, health, counseling and high quality reproductive health services (Para 6.7).

Youth should be actively involved in the planning, implementation and evaluation of development activities that have a direct impact on their daily lives. This is especially important with respect to information, education and communication activities and services concerning reproductive and sexual health, including the prevention of early pregnancies, sex education and the prevention of HIV/AIDS and sexually transmitted diseases (Para 6.15).

Adolescent years are critical in preparing for adult roles in all aspects of life, including marriage, parenthood and wage earning. However the existing national policies and programmes do not adequately address these needs and concerns and do not assist them in making this transition. As adolescents account for one fifth of the population in each of these SAARC countries (Table 1), the economic, social and health costs of this neglect will be enormous. (Choudhury R. H., Paper presented at UNFPA South Asia Conference on the Adolescent, 1998).

Adolescents in India:

There is very little information available on this significant section of the population (which is close to 190 million) and where one out of every five Indian is an adolescent.

There have been some intervention initiatives, mainly by NGOs, to reach adolescents in India mostly confined to a limited number of adolescent girls residing in certain pockets in the country. National programmes like RCH (launched during October 1997 by the Ministry of Health and Family Welfare, GOI) and ICDS (under the Dept. of Women and Child Development, Ministry of Human Resource Development, GOI) have a specific programme component for adolescents. The draft of National Youth Policy also incorporated adolescent as a specific age group to be considered for programme development. Department of Education under Ministry of HRD, Ministry of Social Justice and Empowerment and Ministry of Rural Development and Employment, GOI are also being involved in adolescent programme development. But these programmes are yet to reach a larger section of adolescent population residing in rural India.

Adolescent Reproductive Health Issues

Little is known about adolescent reproductive health in India (Jejeebhoy 1996). Adolescent girls, most of whom being out of school, are particularly vulnerable and neglected coming under the purview of government programmes only when they are pregnant. Consequently, the bulk of available data, drawn from

The National Family Health Survey (1992-93) reports:

- Thirty six percent of married adolescents aged 13 -16 and 64 percent of those aged 17-19 are already mothers or are pregnant with their first child.
- About eight million adolescents, aged 15-19, are already mothers and another two million are pregnant with their first child.
- Worse still, above five million have experienced pregnancy by the time they are 16
- As a consequence, 7.3 percent of pregnancies among women aged 15-19 years resulted in spontaneous abortion (compared to 4.5 percent in the general population).
- In addition, 1.7 percent had experienced an induced abortion. (Jejeebhoy 1999).

Source: NFHS- 1992-93, International Institute of Population Sciences, Mumbai, 1995

National Family Health Survey (1992-93) as well as other sources, focuses on adolescent child bearing rather than reproductive health of the adolescents.

Risk of infant mortality is higher among teenage mothers. There is compelling evidence that teenagers experience greater maternal mortality than women over the age of 20 (Mehra, 1997). Mortality is, however, very low in adolescence. The relative age-specific mortality rates for adolescent girls and boys aged 10-14 and 15-19 years indicate that girl's mortality is indeed higher than boys in this period. Both boys and girls have higher mortality in the older age group, but girl's mortality is often nearly twice as high as boy's as they begin to

experience pregnancy-related health risks (IIPS 1995; Register General of India, Sample Registration System 1992 - mentioned by Greene, M.E. in Regional Working Paper No. 7 of Population Council, 1997). Some kinds of morbidity (cephalopelvic disproportion leading to prolonged labour and its sequelae, toxaemia and eclampsia) are also common among teenagers. The fact that teenagers experience high rates of obstructed labour is both biological (immature skeletal development) and social (social pressure for early marriage and early pregnancy, *ibid.*).

At the crossroads of sexual maturation and reproductive capability on one hand and lack of information on the other, adolescents are vulnerable to sexual experimentation and risk of early pregnancy, RTIs and STIs. Awareness about sexual and physiological changes in adolescence eludes large number of adolescents. Regarding sexual activity, available evidence suggests that between 20 to 30 percent of all males and 10 percent of all females are sexually active during adolescence before marriage (may be under reported, *ibid.*). An UNAIDS survey concludes that 60 percent of new HIV infection cases belong to the 15-24 years age group *(ibid).* Besides, a survey of 716 Senior Secondary School students conducted by a voluntary group revealed that 63 percent of the boys and 37 percent of girls were having sex *(op.cit.).*

What is more alarming is the fact that six out of ten rape victims in Delhi and Mumbai are children below sixteen years of age (Times of India, 1998). The Government estimates that almost 25 percent of all rape victims are adolescents below the age of 16 (Ministry of Social Justice and Empowerment, 1990). Twenty percent of all commercial sex workers in India are adolescents. Another important concern has been sexual abuse by relatives or others. An additional category of rape in India, as elsewhere in the world, is an expression of caste, ethnic, religious or other conflict accomplished through the abuse of a woman from another group.

There is little appeal for young couples to delay the birth of the first child or space out their children. The first child must arrive soon after marriage to establish a girl in her in-laws' home, and if that child is not a boy, then there is additional pressure to produce the second (Greene, M.E., Regional Working Paper No. 7, Population Council, 1997). As a result, the practice of contraception is as low as 7 percent in married adolescents in the age group of 15-19 years (IIPS, 1995), although it ought to be the highest. Awareness about contraception is very vague among married as well as unmarried adolescents. This is regrettable because contraceptives like condom protect against STIs/AIDS in addition to being a birth control method.

Growth and Development during Adolescence

Adolescence is a period of great physical and mental turmoil yet there is a marked lack of data on this important phase of growth. Influences of environment and genetics, in addition to nutrition, play an important role.

Looking at the nutritional status of an adolescent girl (10-18 years), Kapil et. al. (1993) observed that in rural areas of Rajasthan, around 8 percent of girls had first degree of chronic energy deficiency (CED), 6.7 percent had second degree of CED and 78.8 percent suffered from third degree of CED. When nutrient intake was compared with ICMR's Recommended Dietary Allowance (RDA), it was found that calorie intake was deficient by 26 to 36 percent and proteins by 23 to 32 percent in various age groups of 10 to 18 years.

In girls, the growth spurt begins about a year prior to the first menses, increasing their nutritional requirements just when their haemoglobin levels begin to be periodically depleted (Rhode 1990). Anaemia, one of the major determinants of women's mortality and morbidity in pregnancy and their poor

physical performance is perpetuated from the age of 10 years onwards gradually getting worse from 10 to 19 years (Mehra 1997). More recently, micro nutrient deficiency has come up as an important issue. Growth requires energy and an adequate supply of all essential nutrients is known to falter significantly when there is lack of Vitamin-A, Zinc, Calcium, Magnesium, Selenium etc. (Mehra, 1997).

Among the reasons attributed to lack of growth in adolescent girls, important ones are: perpetuation of under-nutrition from childhood to adolescence to womanhood together with other socio-cultural impediments to her growth - such as gender bias, biological stress of adolescence, physical work load and poor access to health services (Mehra, 1997). Dietary pattern of these girls reveal that the diet is high in cereal-based foods while the intake of legumes, animal foods and vegetables including green leafy vegetables is grossly inadequate.

Hardly any data are available on the growth and development status of adolescent boys, although cases of stunted growth and malnutrition / under-nutrition are not uncommon among them.

In a study (Mehra, Goswami 1998) in rural Haryana, body mass index (BMI) was calculated to assess the physical growth and the state of adolescent boys and girls. The BMI values ranged between 14.7 to 18.4 for males and 14.4 to 18.4 for females (both less than 18.5). Poor nutritional intake results in chronic energy deficiency and is the cause for low growth standards of adolescents. Energy consumption levels were assessed separately for boys and girls in terms of dietary intake. This comparison of dietary intake (in terms of nutrients using tables of Indian foods) was made with RDA and showed that both boys and girls had energy deficiency. The extent of energy deficient males ranged from 6 percent to 14.3 percent, while for female adolescents, it ranged from 2 percent to 25.2 percent (Mehra, Gaur and Goswami 1998).

Socio-Cultural influences

In a number of contemporary societies, it does not make sense to talk about adolescence. In many rural areas of the developing world, adult responsibilities including family formation and labour force participation are taken on very early in life without any significant transition period. In many languages, neither the word nor the concept of adolescence exists. In India, for example, adolescence is a controversial notion. It is viewed as an artefact imported from the west, (of the extended formal education in the West) females are "girl children" until they marry (Greene, M.E., 1997). Adolescence itself is a cultural concept that varies across settings and contexts (Villarreal, M, 'Adolescent Fertility: Socio-cultural Issues and Programme Implication' Background Paper, UNFPA Workshop, 1998).

The successful transition from childhood to adulthood is highly valued perhaps because it contains within it the implicit "ideal man and woman" that we want our children to become. Nevertheless, while greater attention is being given on *adolescent health* in many countries of the world, *adolescent development* is less commonly addressed, particularly *adolescent social development*. If we fail to consider the meaning of adolescent social development in the context of each culture when we promote health, we run the risk of endangering resistance because of a perceived threat to deeply held values (Friedman, H.L, Journal of Adolescent Health, 1993).

During adolescence, functions and behaviour become more complex. Along with physical changes, psychologically the individual becomes more capable of abstract thinking, foresight, and internal control. He/she acquires a greater awareness of the environment, capacity for empathy, and idealism. Socially the close relationship and dependence on immediate family begins to give way to more intense relationships with peers and adults outside the family. As new challenges are experienced, new behaviours are acquired, new pleasures are experienced, and new responsibilities are given. However, the physical, psychological, and social changes often occur unevenly. These differ between individuals of the same gender and manifest differently between genders especially with regard to social relationships, which vary widely from culture to culture. These differences can be the source of great anxiety to adolescents and their families, and these anxieties may be compounded by health promotion in so far as it goes against the grain of acceptable and valued

norms of behaviour. (Friedman, H.L, Journal of Adolescent Health, 1993).

Gender relations, particularly gender roles are culturally determined. What is normal or acceptable in one culture may be considered abnormal or unacceptable in another. The best example is 'marriage'. In the west, adolescents themselves take the decision of choosing a partner to 'date' or 'live in' during early and late adolescence. In societies like ours on the other hand, particularly in rural India, decisions like when to marry (usually at early adolescence), whom to marry, how many children to have etc. go by cultural dictates and are usually decided by elders in the family. Any activity (even talking in public) in a mixed gender setting (other than with family members) is allowed for a boy/man to some extent but not for a girl/ woman. This gender discrimination has the sanction of the society perpetrating it.

Data indicate that two out of three adolescent boys and two out of five adolescent girls in India are literate. In fact gender desegregated data clearly shows that significantly fewer number of girls enroll in school and a higher number drop out after the primary level (Article by Sagri Singh, in Implementing a Reproductive Health Agenda in India, Population Council, 1999). There are many reasons why adolescent girls do not go to school including the fact that the school is far from home and the curriculum is not directly related to their future responsibilities. They are expected to learn to cook, to sew, to tend and milk cattle, take care of siblings and other household chores. All this is supposed to be their responsibility: chores that 'good girls' must know. If adolescent girls do not or cannot learn such good 'house wifely' tasks they are burdened with a feeling of guilt arising from ignorance (Conference Report: Expanding Partnership for Adolescent Girls, Organised by CEDPA, UNFPA and PRERANA, 1996). Sometimes withdrawal from school and marriage follows the onset of puberty directly, especially among girls in rural India. Difficulties related to menstruation and the girl's entry into their fertile years interferes with their school attendance. Parents object to schools' lack of clean, sex-segregated toilet facilities where girls can manage their periods in privacy. (Greene M. E., Regional working Paper, No. 7, Population Council, 1997).

Work force participation among adolescents also indicates disproportionately high and invisible work burden shouldered by girls who take on domestic

responsibilities as early as five years of age (Jejeebhoy, 1996; ICRW, 1997; Chaudhury, 1998; Govt. of India, 1998; Mehta, 1998 - mentioned in the article by Sagri Singh, in Implementing a Reproductive Health Agenda in India, Population Council, 1999).

As significant progress has been made in the public health sector to reduce many passively acquired infections, through portable water, better environmental sanitation and better coverage of immunization; behavioural issues are becoming more widely recognised as the key to better health. Many behaviour patterns that influence health have their origin in adolescence. The behaviour patterns are influenced by the environment surrounding adolescents and are highly social in nature - sexual relations, the use of tobacco, alcohol, and other drugs rarely begins as a solitary activity but rather occurs in a social setting. Even seeking help from health service personnel, schoolteachers, counselors or the police depend heavily on how they expect to be received. Unfortunately, the vast majority of adolescents who seek help from health services have access only to those services that are not designed to meet their needs. Compounding the problem is the fact that health workers are neither trained in adolescent health development, or sexuality, nor in interpersonal communication. Given the adolescent's aversion to seek professional help, problems may be exacerbated by the time they finally come for care. While delay is often the consequence of lack of information, knowledge, experience, and money, health professionals tend to hold the adolescents accountable for their actions. Unable to turn to parents for guidance, this stance of the health care personnel only serves to further isolate the adolescents from the adults (Friedman, H.L, Journal of Adolescent Health, 1993).

The transition from childhood to adulthood is sudden in India, especially for young girls, and more so in rural areas, where the majority of these girls live. In this eventful period, school, marriage, health, and work transitions, all take place. Yet we know little about the relationships among these events, the experience of 10 to 14 year old, the change in adolescent lives year by year, and the experience of rural adolescents. Data are urgently needed to sketch out the dense and interlinked transitions that take place in the period. (Greene M. E., Regional Working Papers, Population Council, 1997)

It is therefore essential to know from the adolescent boys and girls their important needs and how these needs may be met taking into consideration the social, cultural and economic constraints that they face.

II: Adolescent Need Assessment in Rural Uttar Pradesh and Rajasthan

Study Objectives:

Overall objective:

Identify the needs of adolescent boys and girls (10-19 years) in the selected rural areas of UP and Rajasthan with a view to formulate intervention strategies to optimise their health and development.

Specific Objectives:

- Prepare a profile of the villages covered in the study with the help of social and resource mapping.

- Determine the status of adolescent boys and girls in the villages covered on the *following adolescent issues*:
  - Growth and development, including awareness about physiological and emotional changes.
  - Practices regarding management of menarche, sources of information and associated misconceptions.
  - Sex and sexuality: attraction to opposite sex, manifestations and management of sexual urge, influences operating.
  - Knowledge and use of contraceptives, sources of information and misconceptions.
  - Knowledge concerning RTIs/STIs/HIV/AIDS and sources of information.
  - Age at marriage: risks, pregnancy, abortions, health consequences, access to services.
  - General health problems (other than reproductive) and access to services.
  - Emotional problems and coping processes.
  - Addictions.
  - Gender issues: roles and responsibilities, perceptions, beliefs and practices including dowry.
  - Parental and community perceptions and responses on the above.
  - The differences across major caste groups wherever possible and desirable.

From the situational analysis, information thus obtained, identifies the emerging needs to be addressed through various interventions.

III: Methodology and Approach

Qualitative Approach in Understanding Adolescent Issues

The gaps in understanding adolescent issues suggest the need for behavioural research, which is community based in addition to biomedical studies. It is important to explore different aspects of the situation of adolescents, with particular reference to their vulnerability to sexual and reproductive ill health, the community and social forces and gender imbalances. Social and cultural correlates of adolescent health and development issues hold the key to address the concerns of adolescents and for coming up with acceptable interventions meant to fulfil their needs.

Participatory Rural Appraisal was used to produce data that reflected the points of view, the ideational perspective, and the cultural definitions of things from the peoples' own intellectual standpoint.

Participatory Approach in the Assessment of Adolescent Needs

Participatory Rural Appraisal (PRA) is a technique intended to enable local people to conduct their own analysis and to plan and take action. Also called Participatory Reflection and Action, it facilitates analysis, presentations and learning by the target population themselves so that they present and own the outcomes. For the purpose of assessment of adolescent needs in the present study the following methods of the Participatory Rural Appraisal (PRA) were used:

- *Social and Resource Mapping*
- *Group Discussion*
- *Prioritisation*
- *Matrix*

The process:

Following the completion of selection of NGO partners in the study, a sensitisation workshop on adolescent health and development was organised for them. They were also oriented about PRA process and tools for this study, which included field trials of the tools to create a level of common understanding among the team-members. Finally teams were formed comprising of personnel from the local NGO and MAMTA for the four study areas.

In each district, a block was selected where the partner NGO was already working and a block resource map drawn to select five villages for the study. After this, the villages where the need assessment was to be conducted were short-listed.

The criteria for selection of villages was -

- ***Geographical representation:*** Giving due representation to geographical location of the villages.
- ***Infrastructure facilities:*** Including availability of school, health facility, water, road, utilities and services. Since these are the indicators of the status of development and are not expected to be present in all the villages, due representation was given to developed, not so developed, and the least developed villages.
- ***Socio-economic status:*** Indicators like level of education, income, occupation was also taken into consideration.
- ***Socio-cultural factors:*** Since customs, traditions, beliefs and practices vary according to ethnicity, it was appropriate to take into account the ethnic composition of the area so that the same could be reflected in the villages selected.
- ***Size of the village:*** Small, medium sized as well as large villages were included (as determined by the number of households) to compare the variation in adolescent needs and behaviour while residing as single or mixed ethnic group in different social dynamics.

Since needs are influenced by all the above factors, the variation in needs was accounted for in terms of the above criteria used in the selection of villages.

The social and resource map prepared with the help of local NGOs was the basis of selection of villages. This information of the area helped us in understanding the area, its people and all those characteristics, which are

needed in the process of planning and implementing adolescent health programmes.

In all, 20 villages (5 from each block in each district of two states) were selected for conducting meetings with adolescents to assess their needs (Table 2).

The team visited the selected villages where they first met the key persons of the villages which were either the Panchayat members/village chief or the informal leaders, teachers, Sathin (grass root level worker of State Women and Child Development Department), worker of Lokjumbish in Phalodi (in Rajasthan). This first meeting with the key persons and elders of the village was the entry point into the community and besides introductions, the purpose and nature of the visit to the village was explained in order to solicit their co-operation. Here, information about the village, services, utilities, population composition etc. was also obtained. Thus, primarily this helped the study team in establishing rapport with the "Gatekeepers" of the community so as to enable the team to start the work.

After the approval of the elders, meetings were held with girls and boys. The Sathin/key persons/workers of Lokjumbish project (in Rajasthan)/Anganwadi workers or NFE teachers would help the study team to gather the boys and girls (10 to19 years) available at that

Table 2 – The adolescent population in the study area

States	NGO Partner in The area	Districts	Blocks	Selected Villages	Village Population	Total population of selected 5 villages in each block.	Expected Adolescent population* (20% of total population)	Expected Total Adolescent population in the study area
Uttar Pradesh	Arthik Anusand-han Kendra	Mirzapur	Halia	Baidha	1155	10515	2103	
				Pakhraud	250			
				Sikta	4500			
				Bhaisor Jer	1250			
				Bhabura	3360			
				Raghunath Singh				
	Social Welfare Institute	Varanasi	Pindra	Thana	5250	24650	4930	
				Surhi	3200			
				Mani	1200			
				Gharkhada	10000			
				Jathi	5000			
Rajasthan	Meera Sansthan	Jodhpur	Phalodi	Ghantiyali	4005	18375	3675	
				Sihada	1450			
				Bitadi	2120			
				Loriya	7136			
				Dhenok	3664			
	Society For Education, Research and Voluntary Action (SERVE)	Jaipur	Jamwa Ramgarh	Saipura	1552	18964	3793	14501
				Naradpura	967			
				Natata	3724			
				Andhi	5598			
				Jamwa Ramgarh	7123			

Note: The profile of the 20 villages are given in annex - 1

moment. At times school teachers were also contacted to organise meeting with the school children within the school premises. Boys and girls gathered at separate places for group discussion. In the boys' group, only the boys were present and the male members of the study team facilitated the group discussion. In the girls' group, the female members of the study team were there to facilitate. The social gap was minimised as all the facilitators were young people.

The number of these meetings slightly varied in each village. Additional meetings were held where the researchers did not find proper representation of all Dhanis (hamlets) or castes of the village or the out of school and school going adolescents, married and unmarried. Separate meetings were held with the parents to take their perceptions on the issues raised by the adolescents.

While the group discussions with the adolescent boys and girls were going on, the elders were working on the social and resource map of the villages along with the research team. Besides being helpful in relating to the village, these

maps would help in planning the interventions at the stage of implementing the programme.

It was observed that the groups got involved in the discussion after initial hesitation. Prioritisation of the issues/needs was also done by the group.

At the end of the day, all notes were checked for completeness and transcription of tape recordings was also done.

IV: Results and Findings

The results and findings are based on the Group Discussion, Prioritisation and Matrix with the adolescent girls and boys and the elders on various health and development issues. The information obtained from two districts each in Rajasthan and Uttar Pradesh has been analysed separately and presented together for comparison. The report presents the trends pertaining to the various issues relating to health and development of adolescent. An effort has also been made to quantify the responses wherever possible.

As the needs of adolescents and the ways to address them vary with the change in culture, and socio-economic context, it was appropriate to treat each district separately, simply because the interventions would be based on the findings obtained in the study. Within each district, boys and girls were taken up separately not only because of obvious differences in their needs but the socio-cultural context would not have allowed combined group of boys and girls to discuss such sensitive issues freely. The married and unmarried adolescents were also interviewed separately.

Socio-economic Profile

The socio-economic profile of the study area encompasses information on utilities, services available, occupations, educational status and caste composition for the four districts in Uttar Pradesh and Rajasthan.

Rajasthan:

Phalodi Block in Jodhpur district of Rajasthan is over 100 km. away from Jodhpur district headquarter and is one of the areas of operation of Meera Sansthan (local NGO). Villages are inhabited by mix of several castes amongst Hindus. Other than upper caste communities like Brahmins, Rajputs, Bishnois etc., large number of lower castes especially SC/STs reside in this area. The higher castes are more literate, rich and thus dominate decision-making and influence and control the rest. The dominant religion is Hinduism followed by Islam.

The main source of income for over 80 percent of the people is agriculture and animal husbandry. However, due to acute water scarcity in the region, they are totally dependent on rainfall. Being a desert area, the quality of the soil is poor and lack of proper rain further depletes it. Hence, land productivity is low. Few are into production of traditional footwear and jewellery.

Literacy level in the study area is very low and unemployment is high. Many are dependent on daily wage earning through unskilled labour. Literacy level is lower amongst girls as compared to boys. There are very few higher secondary schools in villages and children have to travel long distances to go to school. Parents as such do not show much keenness on sending their children to school and prefer them to help in household chores or even working as agriculture labourer. School drop out rate amongst girls is very high due to early marriage.

Gender discrimination is prevalent in terms of education, remarriage, mobility etc. This inequality between men and women is intensified due to lack of education in both. Child marriage is a common practice for boys and girls, the age being lower among females especially from the weaker classes.

Lack of health care is another major problem in the area. Prevalence of diseases like skin ailments, malaria, diarrhoea and anaemia are widely reported. Though there are Sub-Centres and Primary Health Centres, the non-availability of service providers and basic facilities leads to poor utilisation of services. Poor accessibility due to lack of proper transportation adds to the problem. Availability of safe drinking water is very low and women have to walk for miles together to fetch water. Many a times, villagers are forced to buy water tanker worth Rs.100-150. In several cases, lack of access to safe drinking water causes outbreak of water borne diseases.

Jimwa Ramgarh block in Jaipur District of Rajasthan is a large block with 241 villages and around 12 km. away from Jaipur city and well connected by road transport. Presently, SERVE (the local NGO) has an income generating programme (production of *vermi* compost) in some selected villages of the block. Besides this, it also organises mobile health camps and provides health and family life education. As the villages are accessible by roads, this makes access to health services possible. The Government as well as private practitioners who are both qualified and unqualified provide health services in the area. Quacks are still one of the important health service providers for many of these villages.

The villages in this Block are comparatively better in terms of basic civic amenities than the villages in Phalodi block of Jodhpur District with electricity in every village. Educational facilities are also fairly good and many go to Jaipur city for higher studies. All villages have *pucca* roads leading to the village and telephone facility is easily available. Some of the villagers are affluent, owning vehicles and living in brick houses. Most people are into agriculture and animal husbandry, and go to Jaipur to sell their products.

Casteism prevails and upper castes dominate over the lower castes. Gender discrimination is very strong and boys are encouraged to study whereas girls are married off before the onset of menarche. *Muklawa* or *Gauna* takes place as soon as the menarche sets in. Comparing the workload, women work far more than men and contribute significantly in the family income but their status still remains lower with no role in the major decisions of the family.

Uttar Pradesh:

Halia Block, in Mirzapur district of Uttar Pradesh has 185 inhabited villages spreading over an area of 1029.5 square kilometres, with a very low literacy rate and the majority of the inhabitants being scheduled castes and scheduled tribes (mainly 'Kols'). Agriculture is the primary source of livelihood for 80 percent of the population which is mainly rain-fed. Due to exploitation by the upper castes, even a few Kol tribals, who own land, do not have actual possession of it. *Arthik Anusandhan Kendra* (local NGO) is working in an area spreading over 35 villages. Within Halia Block, the development area of AAK comprises of a higher proportion of tribals and scheduled castes. The Kol tribe, however, is at the bottom of the economic and social ladder in the area.

Lack of health care facility is another major problem in the area. Prevalence of diseases like malaria, skin ailments, diarrhoea and anaemia are widely reported. There is only one Primary Health Centre in Halia (Block headquarter) and two Sub Centres near the villages under study. Lack of proper transportation makes access to the PHC very difficult. A Sub-Centre of the PHC in Matwar village always remains closed. Myths and misconceptions in health matters bring these ignorant villagers close to the quacks and faith healers.

Young boys are mostly engaged in the fields as helpers or agricultural labourers. Even in some villages they work in the households as domestic helpers. Girls are predominantly engaged in household chores with hardly any outdoor life.

There are only 10 primary schools in the entire area and one junior high school. Children have to travel long distances to go to school. Parents are not keen on sending their girls to school. They prefer them to help out the family by working at home, taking cattle out or even working as agriculture labour. There are more girls deprived of education than boys.

Pindra Block in Varanasi District of Uttar Pradesh has 98 inhabited villages. Social Welfare Institute (local NGO) caters to the population of 1,18,396 in these villages. Main occupation of people is agriculture, although some people have migrated to Bombay and Calcutta for jobs or business. Pindra is not a tribal area. People from all castes are found here. Child labour is a serious problem. Children are lured into weaving and 'Saree embroidery trades' at a tender age and virtually kept as captives. They are thus denied education and hardly have any leisure time.

The Government as well as private practitioners who are both qualified and unqualified provide health services in this area. Since most of the villages are accessible by road, this makes access to health services possible. However, not all the villages enjoy health facilities. Quacks (*"Jhola Chhaap"* Doctors) are still the main health service providers in these villages.

There are 18 private schools besides the Government schools. In addition to primary schools, there are 15 junior schools. Inter colleges are also within the reach. SWI also runs some non-formal education centres besides the programmes under Total Literacy Campaign. Hence, literacy level is comparatively better among adolescent boys and girls in this area.

In most of the villages television and telephone are within easy reach. Due to exposure to mass media and means of entertainment, people are more enlightened. Some of the villages are affluent, owning vehicles and living in brick houses. People have also migrated to cities, where they are well settled and send money to their folks leading to prosperity of the village and better resources. Village chiefs are women in few villages.

Profile of adolescent boys and girls

The adolescents of the two districts in Rajasthan, are distinct in terms of education and marital status, e.g. the literacy level of adolescents in Jaipur district was better in comparison to Jodhpur amongst both boys and girls. The age of marriage among boys and girls in both the areas was lower than the legal age of marriage i.e. 18 years, but it was reported that girls get married much earlier than boys. Similarly, between Mirzapur and Varanasi districts of Uttar Pradesh, literacy and age of marriage is much higher among adolescents in Varanasi. (Table 3).

Literacy status in Mirzapur district of UP is worse among the four districts, where 62 percent of respondent girls and 40 percent of respondent boys are uneducated.

*** Table 3 – District wise Profile of Adolescent Respondents**

	Rajasthan				Uttar Pradesh			
	Jodhpur		Jaipur		Mirzapur		Varanasi	
Age	**Boys**	**Girls**	**Boys**	**Girls**	**Boys**	**Girls**	**Boys**	**Girls**
10 - 11 Years	26	18	14	3	4	7	3	11
12 - 13 Years	67	19	35	7	28	32	19	20
14 - 15 Years	37	21	26	15	8	22	22	22
16 - 17 Years	8	17	11	8	2	11	18	33
18 - 19 Years	13	8	9	15	6	7	43	27
Total	**151**	**83**	**95**	**48**	**48**	**79**	**105**	**113**
Education								
Primary(1-5)	76 (50%)	28 (34%)	17 (18%)	7 (15%)	9 (19%)	26 (33%)	10 (9%)	22 (19%)
Middle(6 - 8)	54 (36%)	18 (22%)	26 (27%)	13 (27%)	16 (33%)	3 (4%)	31 (30%)	22 (19%)
Secondary(9-10)	12 (8%)	9 (11%)	35 (37%)	12 (25%)	1 (2%)	1	35 (34%)	16 (14%)
Inter11 - 12)	4 (3%)	4 (5%)	5 (5%)	1 (2%)	3 (6%)	–	16 (15%)	29 (26%)
B.A	–	1	–	–	–	–	11 (10%)	3 (3%)
Uneducated	5 (4%)	23 (28%)	12 (13%)	15 (31%)	19(40%)	49 (62%)	2 (2%)	21 (19%)
Total	**151**	**83**	**95**	**48**	**48**	**79**	**105**	**113**
Marital Status								
Married	31 (20%)	16 (19%)	27 (28%)	17 (35%)	13 (27%)	27 (34%)	28 (27%)	37 (32%)
Unmarried	**120**	**67**	**68**	**31**	**35**	**52**	**77**	**76**
Total	*151*	*83*	*95*	*48*	48	79	105	113
Religion								
Muslim	29	10	12	11	–	16	–	4
Hindu	122	73	83	37	48	63	105	109
Christian	–	–	–	–	–	–	–	–
Others	–	–	–	–	–	–	–	–
Total	151	83	95	48	48	79	105	113

Total respondent boys = 151+95+48+105=399

Total respondent girls = 83+48+79+113 = 323

The respondents were predominantly Hindus in all the four districts of UP and Rajasthan. In Jodhpur district of Rajasthan, Hindus mainly comprised of Rajputs, Meghwals, Jats, Brahmins and other castes like Nai, Sunhar, Kumhar, Lohar, Bhil, Dholi, Bishnoi, etc., while in Jaipur district, the Minas, Brahmins, Bunkers and Jats were predominant. Respondents in the Mirzapur district of UP were mainly from Kol tribe. Comparatively less number of boys from Mirzapur, participated in the study because they were not available during the study. The poverty due to under-development of the area compels the adolescent boys to start contributing in the family income early in their adolescence.

Changes perceived during adolescence by boys and girls

The changes stated by the respondents as given in Table 4* include nocturnal emission, development of organs, attraction to opposite sex etc. In Rajasthan, awareness about most prominent features of adolescent growth period was more amongst the boys in comparison to the girls. The adolescents especially girls were unable to articulate the changes and responded only after prompting. There were hardly any differences amongst the girls of the two districts of Rajasthan, whereas boys of Jaipur district were more aware than the boys in the Jodhpur district. In UP, the essential features of sexual maturation mentioned by boys, such as, nocturnal emissions, development of sex organs and attraction to opposite sex are almost similar in both areas. However, general awareness about changes associated with puberty is lacking among boys in rural Mirzapur.

Girls are more aware of changes taking place during adolescence (Table 4). There are hardly any differences in the two districts of UP on essential characteristics like increase in body weight and height, particularly menarche. But there is a lack of awareness about looks, attraction to opposite sex and mood swings in the case of girls from rural Mirzapur.

Issues surrounding menarche

Onset of menarche is the singular eventful experience associated with adolescence in the case of girls about which most girls spoke. Their experiences reflected a lack of information, incorrect and incomplete information, chaos and mismanagement (Table 5).

All sorts of myths and misconceptions about menstrual hygiene were found among girls, irrespective of the development status of the districts in both the states to which they belonged. The hygiene, which is very necessary during this phase, was poor. The situation was no different from that in the slums of Delhi (Mehra, 1997; Misra, Goswami et al, 1995). Surprisingly, mothers are not taken into confidence about menarche and its management. In most cases, brother's wife becomes the most sought-after source of information on menarche. Then next best source of information on menarche, are friends followed by siblings/relatives. Very few girls had shared this information with their mothers and this was found more so in the case of girls who were studying and had mothers who were more educated than the other women of the community. There were few who were aware but were not menstruating. Higher caste girls observed more hygienic practices than others, which include Muslims and the other lower caste amongst Hindus (Table 5). Along with misconceptions, there are lot of taboos associated with menarche (Table 6). It is intriguing to go over the list of *Don'ts* during menarche. Even Muslims practiced rituals like the Hindus for example girls are not allowed in the kitchen during her periods. If the mother and daughter both are menstruating at the same time, then the male member cooks or a neighbour may be called to cook.

* See Annexure from Table 4 onwards

Misconceptions about nocturnal emissions among boys

In Table 7, the experience of "Night Discharge" among boys reveals that this normal physiological process of sexual maturation is a major concern among them. In the absence of right information and inhibitions, "night falls" are perceived as disease and a cause for anxiety and all sorts of misconceptions are associated with this absolutely normal occurrence (Table 7).

Perception of adolescents on Sex and Sexuality

Boys:

Table 8 presents the findings on the perceptions of sex and sexuality issues by adolescent boys and table 9 about girls. Both boys and girls were very shy and hesitant initially. But as the discussion proceeded on to puberty and the emotional as well as physical characteristics associated with it, the group started interacting. The striking difference among boys and girls in all the areas under purview of this study is that boys expressed their sexual desire more in physical act and girls on the emotional sphere.

The most common finding has been the universal "attraction to opposite sex" among boys in all the four areas along with the urge to indulge in sexual activity. Table 8 shows clearly the prevalence of sexual episodes through various manifestations, including masturbation, visits to prostitutes, sex with girls in school and neighbourhood and even homosexuality. The common feature of feeling attracted to opposite sex and fantasising/day dreaming was expressed by all except the Mirzapur respondent boys. This could be because age of marriage is much lower among the Mirzapur boys than the boys of other areas under purview of the study. It may also be true that in Mirzapur, the boys from 'Kols' community did not open up much.

Girls:

Girls do experience attraction to boys but were not really forthcoming about it. The socialisation process plays an important role here, where girls are made to think of, and interact only with the husbands, apart from other male members of her family. Also, there are too many restrictions imposed on their movement and socialisation. The girls said that these restrictions leave them depressed. Some of them did talk about fantasies of film heroes. Only in co-educational schools, girls found an opportunity to talk to boys as in most other environment it was prohibited. Only hush-hush stories of love and romance are reported. The girls found it hard to share their experience of adolescent urges. For some of these girls who belonged to the lower caste and lower socio economic strata, marriage and motherhood coincides with menstruation. Parents are too concerned about their girls when the latter attain sexual maturity (Table 9). So far as respondent girls from Mirzapur were concerned, they hardly experienced adolescent urges or did not open up enough to talk on these issues.

Contraceptive Awareness

Table 10 reveals that girls are better aware of contraceptive options in all the districts of Rajasthan and UP. However, there exist many gaps in the information the girls have. They are aware of women using these methods and many of them want to restrict the number of births after marriage. But they do not know the proper use of the contraceptive methods and have lots of related misconceptions. Only the girls of one particular ethnic group in Mirzapur have mentioned about 'abortion' as one of the method of contraception and also the use of home remedies for birth control.

Boys in all the four districts have incomplete information on contraceptives but boys of Jodhpur district are keen to gain knowledge in order to control population.

TV, health centre, schoolbooks and other women of the village are the sources of information for the girls in all the four districts. It seems that health workers managed to reach only the girls and even with them were unable to communicate correct messages regarding proper use of different contraceptive methods.

Knowledge and source of knowledge on STIs/ RTIs/HIV/AIDS

Table 11 presents a comparison among boys and girls between the districts of two states on the knowledge and source of knowledge on STIs/RTIs/HIV/AIDS. In case of STIs/RTIs, girls in both the districts of Rajasthan

are not aware of it though in Jaipur, some girls have heard of STIs but were unable to explain it. Although many of the respondents shared that they are having white vaginal discharge, they are unaware of the reason behind it and have accepted it as a normal phenomenon after marriage.

Boys of all the districts do not have knowledge about STIs/RTIs. Only educated upper caste boys of Jodhpur, a few in Jaipur in Rajasthan and Varanasi in UP, had heard about it. The source of information for both boys and girls was mainly television. In the villages where there was no electricity, especially in Mirzapur study area, the people had no information on this aspect.

Girls in both the districts had incomplete information on HIV/AIDS though some educated girls of Jodhpur, particularly the upper caste girls, were slightly better informed about it as compared to the rest. But many misconceptions regarding its prevention and mode of spread existed. The sources of information are schoolbooks, TV, newspapers and friends. Some girls in Jodhpur got the basic information on HIV/AIDS from Sathin (grass root level workers of 'State Women and Child Development Department').

Knowledge level of boys on HIV/AIDS is similar to that of girls. There is general awareness about HIV/AIDS, but they are not aware of causes and prevention. Boys in Rajasthan could not recall the source of information but respondent boys from Varanasi heard about it on TV.

Age at marriage for boys and girls

As shown in Table 12, marriage age of boys is higher in Jaipur as compared to Jodhpur though in some areas of Jaipur they are married off as early as 8 to 9 years. Jodhpur boys though aware of the legal age for marriage, were not following it strictly. It was observed during the group discussions with the adolescent boys that marriage age was higher for educated boys. Educational status of parents also had an effect on the marriage age of both boys and girls.

Age at marriage in both the study districts amongst girls is very low, slightly lower in Jodhpur in comparison to Jaipur. However, age at marriage is higher for boys than girls. Few educated girls in Jodhpur were aware of legal age for marriage (18 years for girls and 21 years for boys) and mentioned that nowadays, educated parents do not want to marry their daughters early. This was also observed in Jaipur. But child marriages are still prevalent mainly under social pressure (for both boys and girls). However, the age of *effective marriage* is higher now.

In both the districts, *Muklawa* ('effective marriage' - a ceremony when girl is *sent* to boy's house to stay together) is closely associated with girl's 'sexual maturation' (here it means 'onset of menarche'). In Jodhpur, *Muklawa* is often performed along with marriage in order to save money. In some castes like Bishnoi community, girl's marriage is combined with *Mrituya Bhoj* (a ceremonial community feast after *death* of anyone) to economise. In some villages of Jaipur, all the daughters are married in one wedding even if they are 5 to 6 years old, for economic reasons.

In UP, caste plays an important role in determining the age of marriage. However, marriage takes place earlier in Mirzapur area even in the case of higher castes. Age of marriage is higher for boys than girls in Mirzapur and Varanasi.

As revealed during the study that girls are married as early as 10-13 years of age in some communities at both the UP districts, in spite of better literacy and exposure to electronic media. Other communities, including Muslims, reported higher age of marriage in comparison to the scheduled castes/tribes. *Gauna* (same as '*Muklawa*' in Rajasthan) practice is undergoing transition and it takes place simultaneously with marriage, particularly among the 'Kol' community in Mirzapur.

Marriages are mostly fixed by the elders of the family and in many cases even boys do not have a say in it though they can communicate their likes/dislikes indirectly, through siblings or relatives.

Socio-cultural Determinants of age of marriage

Table 13 brings out the various socio-cultural determinants of age of marriage. It is important to understand the type of factors influencing the age of marriage, particularly in the case of girls. As shown in Table 13, boys reported no such determinants in

Rajasthan and only two determinants in UP. Having sons are viewed as an opportunity by the parents for negotiating dowry. The appropriate time for marrying the son goes with the family status, educational level and occupation of the boy.

Conventions peculiar to a particular class or society dictate the age of marriage. Strong social pressures, such as boycott and sanctions, are instrumental in enforcing the conventional age for marriage especially in the case of girls.

The parents did talk about the pressure from the elders of the family. Especially in Rajput community in Rajasthan, the family members find it difficult to deny the decision when the grandfather fixes a match for the boy/girl and informs the family.

Parents consider the girl as a liability besides being worried about her security and feel that to marry her is the best way to get over with their responsibility. The community also socially looks down upon the family with unmarried girls. In most cases, the onset of menarche signals the marriage. Though in Rajasthan especially in Jaipur, dowry was not very rampant but was given for a happy married life. In Jodhpur, dowry existed mainly amongst the Rajput community. Capacity to pay dowry may hasten or delay marriage. Educational status of girls also influenced their age at marriage being the higher the education, the later the age of marriage. However, in many places school dropouts were due to early marriage. Gender discrimination played an important role as girls were considered "others' property" and therefore sooner they were married, the better it is for the family.

General Health Problems

Table 14 shows various health problems experienced by adolescent boys and girls. The reported commonest health problems among boys of all the four districts of Rajasthan and UP were '*weakness*', 'cough and cold', 'stomach disorders', 'eye infection' etc. Though sexual health problems have been mentioned, which were mainly the ones related to the *misconceptions linked with 'masturbation' and 'night falls'* but very few have come forward to discuss the same.

In the case of girls, the health problems were mainly menstruation related. Many, though suffering from problem of 'white vaginal discharge' were unable to relate it as a health problem.

Emotional problems experienced by adolescent boys and girls

As per Table 15 boys and girls came up with many emotional problems associated with adolescence phase of life. But boys were more revealing and it was difficult for many girls to express their emotional problems.

The commonest expression by boys and girls in all the four study districts was the feeling of anger due to restrictions and control on them. Boys were agitated and girls were mostly depressed. Boys wanted to express their sexual desires but were agitated because of the socio-cultural binding on them. Their willingness to experiment leads to risk taking behaviour and indulgence in addiction. They also feel tensed and insecure about their future due to high set goals. Another complaint of boys being that the elders controls their lives to the extent that they feel suffocated.

Many restrictions imposed on girls make them feel depressed and irritable which at times lead to a rebellious nature. Restrictions to socialise make them docile and submissive. They feel agitated and irritated

with parents due to excessive workload on them. Gender discrimination especially in terms of education and mobility depresses them. Though they get attracted towards boys, they are unable to express their desires due to submissiveness.

Addictions among Adolescent Boys

The boys also perceived *taking some form of addiction* as the change, which occurs during adolescence. Smoking, tobacco chewing, *Gutka* are widely accepted form of drug use among young boys and elderly men. Boys of Jodhpur and Varanasi mentioned about some pharmaceutical drugs used orally. Mendrex, Opium (crude), Ganja (Marijuana) and alcohol are liked by boys in other two districts. Alcohol and other forms of substance abuse were less common in these areas. No addictions were however reported among girls in all the districts (Table16) but the girls in UP mentioned that some village women do smoke and chew tobacco.

Gender issues - beliefs and practices

From Table 17 one can clearly see discrimination in terms of gender in all aspects, more so in the case of education, food, socialisation, marriage, and role obligations.

Though not much discrimination has been reported in case of food and nutrition, but girls/women eat last after serving the 'men' of the family. Less discrimination exists between boys and girls for elementary education but there are definite biases, which the parents of all the four districts have for boys, in terms of continuing education or encouragement for higher education.

Girls reported that sometimes they are made to drop out or never admitted because of household duties. It was reported that in villages of Varanasi district, parents preferred sending their boys even to the private schools. Parents themselves feel that the girls should learn to do household chores instead of going to school, as this is what they have to do after they get married. On the other hand they believe that boys need to study so that they can support them in their old age. A slight change in this trend has been observed in some villages of Rajasthan like in "Loriya", where quite a few of the women are educated and they are taking active initiative to educate their daughters. Some girls of this village are even studying in college.

In some villages, the mothers asked us to speak to their daughters for continuing education. Also in some cases, women came after the meeting and requested the study team members to pursue their husbands, so that their daughters can continue their studies.

Boys are preferred over girls' right from their birth. Even mother's status is enhanced after she gives birth to a male baby and the birth is celebrated, as reported by women in the group meetings. This rarely happens when a girl is born because they are thought to be a burden and liability for the parents as well as the family. In one district, the group meetings revealed that the girls are perceived as 'other's property' (of the boy whom she will be married to and of his family).

Girls are barred from free mixing with the opposite sex though a few educated upper caste girls in Jodhpur stated that they talk to boys studying in their school and their parents are also not very strict about it. They do not have any say in their marriage and are not allowed to meet the husband till '*Muklawa*' (Effective Marriage - a ceremony when the girl is sent to boy's house to stay together) is done. Decisions are simply imposed on them. Their roles and responsibilities are all confined to home.

The scourge of dowry further makes the life of a girl and her parents miserable, while the boy and his family consider it as a legitimate expectation. Although organising dowry in the form of cash or kind is a norm for some communities like 'Rajput' in Rajasthan but for others under purview of this study, it comes about because girl's parents feel that paying dowry can bring in happiness in daughter's married life. (Table 17).

It was reported from some villages that men cannot discuss important matters with their wives, because the underlying fear is that they will be looked down upon by other men folk of the village, if they do so.

In both the states *no widow re-marriage* is allowed (here it means 'no marriage ceremony can be

performed') 'though she can go away with the person of the family's choice or the husband's younger brother can *'give her the bangle' (means the man is accepting her as wife)* in Rajasthan. On the other hand, men can remarry without any restrictions.

Needs Identified by Adolescent Girls and Their Prioritisation

As shown in Table 18A, girls, especially in Jodhpur district of Rajasthan, have been unable to articulate their needs though some have given foremost priority to freedom from mobility restrictions.

In comparison to Jodhpur, Jaipur girls (Table 18A) have been more expressive in stating their needs. Needs like 'freedom from mobility restrictions', 'less burden of household work', 'education of villagers to understand the importance of education' and 'no early marriage' have been ranked first followed by 'decision making power to girls', 'employment opportunities', 'no restriction to socialise' and 'no family pressure for marriage'. Similarly, girls in Mirzapur district of UP have also expressed themselves through fewer needs as compared to girls in Varanasi District (Table 18B). Freedom from social/parental restrictions enjoys rank one along with education in both the districts.

The girls in UP do not want early marriage, which is assigned second rank by girls in Varanasi District. Girls in Mirzapur District want the workloads on them to be reduced and have assigned it rank two. In Varanasi, the need to scrap discrimination on the basis of sex has been given rank three.

As is obvious in both the Table 18A and 18B, there is considerable overlapping in the ranking of needs which is attributable to differences in perception of adolescent girls in different places. However, reproductive health needs including management of menstruation have not appeared as one of the needs of respondent girls in Rajasthan, but UP girls did mention about it much later in order of prioritisation. Only the respondent girls from Mirzapur mentioned their need of being informed about 'contraceptives' among their foremost needs together with 'knowledge about STI/AIDS'.

Needs Identified by Adolescent Boys and their Prioritization

The boys in Jodhpur districts of Rajasthan (Table 19A), ranked basic amenities like 'drinking water facility', 'provision of high school' and 'knowledge on nutritious food', as the foremost needs followed by 'knowledge on health matters' and 'provision of health care facilities', 'employment opportunities' and 'provision of roads in the village'. Jaipur boys have rated health care facility and knowledge to control population as their first priority besides knowledge and availability of nutritious food, facility for higher education and employment opportunities.

In Jodhpur, the most felt need is the provision of basic amenities whereas in Jaipur emphasis has been laid on provision of health care facilities followed by education and employment opportunities. Some sort of recreational facility has also been mentioned as one of the felt needs by boys of both the districts.

In Uttar Pradesh (Table 19B) 'employment opportunities' has been ranked among the foremost needs along with the 'knowledge on health matters' and 'treatment of health problems'. Boys from Mirzapur have also rated education and school facility as their first priority. Second rank has been assigned to 'repossession of land' by boys at Mirzapur while the respondent boys at Varanasi given same rank to the need of a 'counselling centre' and 'knowledge on sex and sexuality'. Knowledge of adolescent issues and development concerns during adolescence has been voiced in both the districts of UP and assigned rank number three. In Varanasi area, 'scope to mix with girls' and 'facility for higher education', appeared as third priority for the boys. Boys in Varanasi want the communication gap between family members and the growing adolescents to be minimised and have assigned rank six to it. Need of a 'music club' and 'pollution free environment' have been assigned the last two ranks (7 and 8) by adolescent boys in Varanasi District.

Table 19A and 19B shows the comparative picture of needs identified by adolescents and their prioritisation in UP and Rajasthan. It could be noticed that though the needs expressed are similar, they have been ranked in order of importance attached to these needs.

Parental Concerns for Boys

Elders, including parents and the key persons of the village were also met separately to understand their concerns about adolescent boys in the village. One of the study objective was to cross check the parental perception with the needs expressed by adolescents i.e. triangulation.

Table 20 shows a lot of similarity between the needs identified by adolescents and the elders where the elders also show their concerns about the emotional problems of the adolescents. Besides showing concern for their education, nutritional status and employment, they are also worried about poor knowledge of adolescents on sex and sexuality and misconceptions related to it. Elders have expressed grave concern about their young ones being rebellious, and the existing communication gap between them and their children. Elders came out more strongly on this issue, which were not really mentioned by the adolescents.

Parental concerns about adolescent girls

Women from the selected villages were met separately for the purpose of knowing their perceptions about adolescents and their needs. Table 21 shows that the needs expressed by the women are similar to those expressed by the girls like excessive work load, lack of education, gender biases, no decision making power and lack of knowledge about STIs/RTIs and HIV/AIDS.

Needs identified by women are numerous which includes concern on communication gap between them and their daughters. There are many needs which are common between all the four districts of Rajasthan and UP, such as 'poor knowledge on contraceptives', 'incomplete information and misconceptions related to menarche management', 'gender bias' etc. The concerns expressed by women in the villages of Varanasi district of UP (not found in Mirzapur) are the 'management of menarche', 'premarital sex', 'lack of appreciation for the many chores that women perform', 'lack of awareness for earning livelihood' and 'income generation programmes'. Women have been more expressive in stating the needs more or less in line with those expressed by the adolescent girls.

Treatment seeking behaviour: Rajasthan:

Boys - Jodhpur district:

Matrix - 1 presents the treatment seeking behaviour of boys in Jodhpur district. Ratings assigned to the criteria underlying choice of health service range from 1 to 5 where 1 is most preferred and 5 is least preferred. Witchcraft, quacks (locally called '*Jhola Chhaap Doctors*' - unqualified medical practitioners), government dispensary, household remedies and private qualified doctors are the health service providers available to these villagers. Witchcraft is used because it is locally available, less expensive and some people are unaware of other services available in their area. A few of the respondent boys stated that they go to witchcraft practitioners because of trust on them. Quacks are chosen because they are said to be locally available and besides being less expensive, people go to them during emergency. Government dispensaries are approached only in case of acute disease but many stated that they are expensive. Some use household remedies in case of emergency. Private qualified doctors being very expensive, are approached only in case of major health problem though people do believe that they give medicine which is effective.

Girls - Jodhpur District:

Matrix - 2 shows the treatment seeking behaviour of girls/women in Jodhpur district. Witchcraft, quacks, government dispensary, household remedies and private qualified doctors are the health service providers available to these villagers. Many women though suffering from reproductive health problems are unaware of it and accept it as their fate or as a

normal phenomenon in a woman's life. Witchcraft/*Ojha* is the most preferred source for providing treatment and majority of women approach them first. The women not only trust them but also they are locally available, less expensive and as stated by respondents that they do provide good treatment. Quacks are also approached because they are locally available and provide good treatment. Government dispensaries are approached mainly in case of acute disease. Some respondents mentioned that they are not very expensive and provide good treatment. Very few respondents have trust on government health services in the area because of non-availability of doctors most of the time and not being easily accessible. Household remedies are also used by many as they are locally available and less expensive. Private qualified doctors being very expensive, are approached seldom, only in case of major health problems.

Boys - Jaipur District:

Treatment seeking behaviour of adolescent boys in Jaipur is shown in Matrix - 3. In the event of falling sick, the options available to them are *Ojha* (spiritual healer) government hospitals (CHC, PHC and Sub-centres), Quacks, private qualified doctors and household remedies. Many go to quacks, as they are less expensive and locally available. Many go to *Ojha*s also for the same reasons. Few are unaware of other health services available in their area. Majority of them go to the government dispensaries in case of major health problem, though some feel that they are not very expensive and easily accessible. Few use these government health care services in emergency.

Girls - Jaipur District:

Matrix - 4 presents the treatment seeking behaviour of girls/women in Jaipur district. The matrix shows that many women have full faith in *Ojha*s and the respondent women feel that they provide good treatment besides being less expensive and locally available. Many go to quacks also for the same reason as mentioned above. Though the government health care services are quite accessible and approachable, many people do not utilise the services because most of the time the doctors are not available. Government health centres are visited only in case of an emergency. Private qualified doctors are also visited by some, though being very expensive do provide good treatment.

Uttar Pradesh:

Boys and girls - Mirzapur District:

Matrix 5 presents the scenario on the type of health services preferred by adolescent boys and girls in Mirzapur District study area. Witchcraft, quacks (*Jhola Chhaap Doctors*), government dispensary, elderly women, household remedies and private qualified doctors are the health service providers available to these villagers. Witchcraft is used because it is locally available, less expensive and people trust it. Quacks (*Jhola Chhaap Doctors*) are chosen because they provide good treatment, people trust them and they give medicine. Government dispensary although provides good treatment, it is not accessible, expensive, and medicine is seldom provided. Elderly women, either in the household or in the village are also approached for treatment of ailments and they are locally available, less expensive and people trust them. Household remedies have the advantage of being locally available and are less expensive. Private qualified doctors are difficult to approach and are very expensive, although they may be providing good treatment and giving medicine.

Boys and girls - Varanasi District:

A different matrix (6) emerged while putting together the responses from adolescent boys and girls of Varanasi district. This matrix shows the participants' manner of coping with illness in a variety of ways. In the event of falling sick, the options available to them are rest, no treatment, Block Hospital, Quacks (*Jhola Chhaap Doctors*), *Ojha* (spiritual healer), qualified doctor, household remedies and District Hospital. Experience is reportedly not favourable in the case of Block Hospital, which is used only in emergency. District hospital is visited as a last resort, in emergency and people are satisfied with the service. However, people believe in taking rest when they fall sick and elders ask the adolescents to do so. There is also a belief that the ailment will be automatically cured and treatment is not required, as told by elders, although the experience has generally not been favourable. Quacks (*Jhola Chhaap Doctors*) are easily accessible and people have faith in them. *Ojhas* (Spiritual healers) also thrive on people's trust and they are easily accessible, although people go to them in desperation.

V: Discussion

Socio-economic profile of the study area

The availability and accessibility of infrastructure facilities and basic necessities like drinking water, electricity, accessibility by road, telephone and television differed in the villages of the four districts. The rural areas of Jaipur in Rajasthan and Varanasi in UP under purview of this study, are much more affluent with better facilities in comparison with rural Jodhpur (Rajasthan) and Mirzapur (UP). But there is not much difference in terms of health facilities and women's empowerment. The occupation is mainly agriculture in all the villages in the study area.

Though rural Jaipur (Rajasthan) and rural Varanasi (UP) has a better availability and accessibility to basic amenities and services and at the same time has comparatively better educational and health facilities, service utilisation is still very poor. *Active advocacy is required with service providers from the health and education sector to make the services more user friendly in all the areas. Simultaneously, sensitisation and awareness generation at the community level has to be done so that people, particularly the adolescents, can make use of the available services.*

Literacy status in Varanasi (UP) is relatively better but in Mirzapur (UP) it is the least among the four study areas. Overall, the literacy among girls remains low in all the four districts in comparison to boys. *So, girl's education needs attention in all the study areas.* The educational status of respondents indicates *the need for overall improvement in education in all the study areas. Therefore, emphasis should be on continuing education rather than on enrolment. Girl's education requires specific attention in terms of enrolment as well as continuation of study in all the areas.*

There is exploitation of young boys because of lack of education, less alternative income opportunities other than agriculture and lack of appropriate skills. As reported in rural Mirzapur, some adolescent boys were working as domestic helpers in the households of powerful landlords, which they did not like. Women go out and work as daily wage earners on farms, dams etc. *Initiative required for creating linkages for alternative job opportunities and skill development.*

Caste based discrimination, which still persists almost everywhere in the study area, has a very adverse impact on the psychological development of adolescents. *Human rights issues have to be built into all intervention initiatives in the area.*

Age at marriage has been low for all the respondent boys and girls in every district, *which calls for immediate intervention. The significantly low marriage-age among girls which results in discontinuing their school education needs special attention in all the areas.*

Growth and Development Characteristics

The awareness about most prominent features of adolescent growth period was more amongst boys in comparison to girls. The girls were unable to articulate the changes and required prompting to respond. The fact that the girls were not being able to express, reaffirms the basic understanding that they do not have the access, opportunities and exposure as compared to boys. *This demands creation of more comfortable and encouraging environment for girls not only for giving correct information about the changes but also to be able to discuss growth and development issues including sex and sexuality.*

The lack of correct information, chaos and mismanagement regarding menarche along with myths and misconceptions were found among girls irrespective of the development status of the districts or states to which they belonged.

Parental interaction regarding growth and development, especially menarche, is negligible and

sources of information are brother's wife, friends, siblings and relatives. Some sort of parental communication was found in the case of girls who were studying and had educated mothers. Higher caste girls observe more hygienic practices than others, which includes Muslims and the other lower caste Hindus. Misconceptions and taboos associated with menarche existed not only in Hindus but also among Muslims. It is important to disseminate correct information about menarche in all the districts.

In the absence of right information, "night falls" are viewed as a disease and a cause for anxiety and *many misconceptions are associated with this which need to be cleared.*

Neither the boys nor the girls were able to identify the role of additional nutrition in growth and development during the adolescent phase. However, while expressing their needs, boys mentioned their need for information on this subject. *This is important aspect which needs to be incorporated for intervention involving both adolescents and their parents in all the areas with a special emphasis on girls' nutrition.*

Contraceptive Awareness

Though girls are much better aware of contraceptive options in all the districts in the study area, except Mirzapur, there is a lack of correct information on proper use of contraceptives and misconceptions about side effects among the adolescents and their parents. In case of parents, knowledge gap together with the taboo imposed on discussing this issue prevents the availability of most suitable source of information to adolescents on the subject. *This issue needs to be looked into.* The incomplete knowledge coupled with lack of availability does not encourage married adolescent to use contraceptives. Boys in both the districts have incomplete information on contraceptives but many are keen to gain knowledge in order to control their family size.

TV, health worker ANM, NGOs and Schools are sources of information on contraceptives. Girls did not talk of premarital use of contraceptives and neither was any incident of pregnancy prior to marriage reported during the discussion.

The existing status of knowledge about contraceptive options calls for dissemination of correct information

on methods, its proper use to all the adolescent boys and girls irrespective of their marital status. It is also important to identify additional channels for information dissemination and simultaneously strengthen the existing channels for correctness of information which could be parents and service providers of that area.

Knowledge about STIs/RTIs/HIV/AIDS

There is a general lack of information on STIs/RTIs amongst girls in all the districts under purview of the study in Rajasthan and UP. Information on HIV/AIDS in girls of both the districts of Rajasthan was incomplete though some educated upper caste girls of Jodhpur were slightly better informed. The girls in Varanasi (UP) are comparatively better informed about HIV/AIDS through TV. But misconceptions abound with regard to its mode of transmission.

Boys in both the districts of Rajasthan do not have knowledge on STIs/RTIs. Only educated upper caste boys of Jodhpur and a few in Jaipur had heard about it. In Mirzapur, there is hardly any awareness about either the RTIs or HIV/AIDS. Boys are somewhat knowledgeable about STIs in Varanasi.

Knowledge level of Rajasthan boys on HIV/AIDS is similar to that of girls. But in Mirzapur boys have not even heard of HIV/AIDS.

The *lack of proper maintenance of menstrual hygiene and lack of knowledge regarding reasons, manifestation and complication of RTIs among both boys and girls in the area needs to be given special attention to reduce the grave health risks for the girls.* The mobility of the population to nearby city (mostly by boys/men) from rural Jaipur and Varanasi brings in additional risk of STIs and HIV infection (increasing in all major cities in India, an urban to rural trend is also being reported) to both the boys and in turn to the girls. The women in these areas admitted that they could never question or refuse men in the matter of sex. *Along with awareness, early detection and facility for complete treatment of STIs with maintenance of confidentiality has to be considered as one of the element for intervention. 'Teachers' could be a potential group in Varanasi (UP) and Jaipur (Rajasthan) who can be trained to impart information related to these issues, because comparatively higher number of adolescent boys and girls are attending schools in these areas.* Expression of boys during discussion on the issues like 'changes perceived during adolescence' and on 'sex and sexuality' *calls for behavioural intervention with special focus on out of school adolescent boys.*

Age at marriage

Marriage age for boys and girls remains fairly low in both the districts of Rajasthan. Socio-cultural determinants play a predominant role in determining the age of marriage. These include social conventions about age of marriage and associated social sanctions, capacity to pay dowry and educational status of girls and their parents.

As mentioned earlier, the early age of marriage pulls out the adolescent girls from the school and puts her in a situation which affects her physical growth in several ways. She has to marry a stranger who has been chosen by parents and go to in-laws' house and adjust herself in this new environment and prove herself as a good daughter-in-law, wife and a competent woman to bear and rear a child as early as possible, for which she is physiologically and mentally unprepared. This enormous physical and mental stress coupled with lack of information and access to contraceptives also contributes for early pregnancy and pregnancy related complications due to incomplete physical growth.

Increasing the age at marriage by working out specific strategies to address all the socio-cultural determinants would be major challenge in the process of programme development for adolescents.

General Health Problems

The adolescent boys of all the areas are mostly concerned with other health problems and give low priority to reproductive health. Similarly girls had also mentioned general health problems although they expressed their concern over menstrual problems and RTIs as well. *This calls for development of a*

comprehensive health package, encompassing reproductive health services for adolescent boys and girls in the area. An effort has to be made to gear up the capacity and bringing in sensitivity of existing health service providers in government as well as private sector towards adolescent health concerns.

Emotional Problems of Boys and Girls

A common expression of most of the respondents in the study area has been 'control and restrictions' on them by parents and the elders in the family leading to anger, depression and irritability, more so in case of girls.

The findings of the study indicate the requirement of support to address the emotional needs of adolescents. *It calls for creation of a place where they can go and share their anxieties and concerns as well as seek support whenever required. An effort has also to be made to create an enabling environment in the community, where special emotional needs of adolescents are acknowledged.*

Addictions

The study revealed the existence of some form of drug (mainly tobacco in the form of cigarette, *Bidi, Gutka* etc.) use in the area among adolescent boys. But the extent of clarity on the harmful effect of these substances amongst the boys is yet to be explored further. The mobility of the boys from the rural areas of Jaipur, Jodhpur (Rajasthan) and Varanasi (UP) to the nearest city make them vulnerable towards other form of more harmful and dependency creating substances. *The support services to be developed must include scope to address the issue of drug use prevention.*

Gender Issues

The outcome of the study reaffirmed the strong gender based discrimination with the girls, particularly in continuing education, defining roles and responsibilities, movements and socialisation, marriage and remarriage etc. Age old customs and practices are continuing, justifying preference for a male child as care giver during the old age, which is increasingly being denied by their sons in these villages as reported. Yet, there is little realisation that girls can also efficiently take care of their elderly parents even after marriage. *The gender discrimination with girls has come up several times while discussing different issues with boys and girls and also in the discussions with parents, which needs to be incorporated as a basic element of overall intervention design with adolescents.*

Needs Identified by Adolescent Boys and Girls

The needs expressed by respondent boys and girls are quite different. The major needs of the girls has been 'freedom from mobility restrictions', 'less burden of household work', 'education amongst villagers to understand the importance of education' and 'no early marriage'. On the other hand, boy's needs related to improvement in basic amenities like 'drinking water facility', 'provision of high school' and 'knowledge on nutritious food', 'provision of health care facilities', 'employment opportunities' and 'provision of roads in the village' etc. The adolescent health needs are of lesser priority for both boys and girls.

These suggest dissemination of findings to sensitise the elders and gatekeepers of the community in the study area is necessary and then facilitate them to develop plans to address the needs expressed by adolescents in their area. Also, they can be guided to form linkages for improvement in infrastructural facilities and quality of service in the area.

Parental Concerns for Boys

The parents and elders are mainly concerned about the emotional problems of the adolescents along with concern for their education, nutritional status and employment. They are also worried about poor knowledge of adolescents and misconceptions related to sex and sexuality. Elders have expressed grave concern about their young ones being rebellious, and the existing communication gap between them and their children.

Parental concerns For Girls

The needs expressed by women are similar to those expressed by the girls like excessive work load, education, gender biases, no decision making power, and lack of knowledge about STIs/RTIs including HIV/AIDS. But 'end to dowry' is a strong need expressed by all women in Uttar Pradesh and in one district of Rajasthan. Needs identified by women include concern on communication gap between them and their daughters. There are many common needs between the two districts of Rajasthan, such as poor knowledge on contraceptives, incomplete information and misconceptions related to menarche management, gender bias etc. Along with these needs for the adolescent girls the women in Varanasi district of UP added the need of 'awareness for earning livelihood' and 'income generation programmes', as well as 'appreciation for the many chores that women perform'.

These clearly indicate the need for information to elders in the community, particularly the parents to be able to understand the 'adolescence' and develop skills to communicate with them to minimise the communication gap. Parents could be involved in advocating for adolescent friendly services.

Treatment seeking behaviour

Treatment seeking behaviour is similar in all the four districts in the study area in terms of preference of the service provider. The Witchcraft/*Ojha* (spiritual healer) and the quacks (unqualified private practitioners) are most preferred because they are locally available, less expensive, have trust on them and they provide good treatment. Only in case of any acute illness, they go to government health centres since such services are not easily accessible (mentioned non-availability of doctors most of the time) and sometimes expensive (some doctors charge money and most of the medicines prescribed has to be bought from outside). Some of the respondents reported that some PHCs always refer the cases to CHC/district/state hospital. But some of them did mention that they are not very expensive and do provide good treatment. Private qualified doctors as being very expensive are approached only in case of major health problem though people do believe that they give good medicines, which are effective.

In the case of girls, many though suffering from reproductive health problems are unaware of it and accept it as their fate or as a normal phenomenon in a woman's life.

VI: Need Based Programme Implication

The study was conducted to identify the issues concerning adolescent boys and girls and know the parental perceptions on the same. This was done with a view to formulate intervention strategies to optimise their health and development.

Since the information required was relatively sensitive and personal, qualitative methodology was used. The participatory rural appraisal techniques like social and resource mapping, group discussion, prioritisation, matrix and triangulation were used by a team comprising

Issues emerged:

Boys	Girls
Incomplete and inaccurate information on bodily changes.	Lack of information and discomfort in articulating the bodily changes.
Parental communication gap and no other source of information on bodily changes except friends.	Parental communication gap and no other source of information on bodily changes.
Number of misconceptions on masturbation and nocturnal emission.	Lack of awareness on menarche management and hesitation amongst mothers to talk on this issue.
Masturbation is a wrong practice according to parents.	Many misconceptions, blind faith and taboos attached to menarche management.
Risk taking sexual behaviour; indulging in sex with animals, visiting sex workers.	Poor knowledge on sex and sexuality. Unable to articulate the same.
Sources of information on sexuality are literature and films locally available and friends.	Restrictions on girls on interacting with the opposite sex. They fantasise but feel uncomfortable in even talking about it.
	Social pressure on parents leading mobility restriction on girls and early marriage.
Incomplete and poor knowledge on contraceptives. Lack of awareness on male responsibility. Misconceptions related to usage of male contraceptive methods (permanent and temporary).	Incomplete and poor knowledge on contraceptives. Misconceptions related to usage of male contraceptive methods (permanent and temporary).
No information on STIs and RTIs.	Very few had heard of STIs but not aware of RTIs.
Had heard of AIDS but did not have a clear understanding of it.	Had heard of AIDS but did not have a clear understanding of it.
Early marriage as decided by parents.	Menarche signals marriage. Girls' consent not taken. Early marriage a barrier for continuing education.
Insecure about future (employment)	Girls and women expressed needs to learn skills.
Want more involvement in the decisions concerning them.	Expressed desire to reduce work load and men to share responsibilities.
Addiction amongst boys. Accepted norm though parental concern is there.	No addiction amongst girls though elderly women were reported to indulge in it.
Preference of boy over girl right from birth.	Preference of boy over girl right from birth.
Boys encouraged to study even in private schools.	Girls made to work at home and take care of younger siblings.
Expressed desire for a place to share their thoughts.	
Local healers and unqualified practitioners preferred over govt. dispensaries.	Go as per parents' desire.

of personnel from MAMTA and NGOs. The team first contacted the key persons of the village and then met the adolescents. The parents' perceptions on the key issues concerning the adolescents were also collected.

Through this exercise we gained insights into the needs, perceptions and problems of the adolescents.

Intervention strategies:

General

Based on the above issues there is a need to work with elders in the community and the service providers like the health care providers, the ICDS workers and the teachers along with the adolescents. They need to be sensitized and made aware of the problems expressed by the adolescent.

The intervention would include:

- Sensitizing and creating awareness in the community on adolescent health and development (AHD) issues.
- Educating and disseminating information amongst adolescent on the above mentioned issues. This is to be done through participatory method that not only gives correct information but also aims at demystifying myths.
- Establishing linkages with the local service providers for adolescent health.
- Sensitising the Tehsil and District level government officials, health service providers from government and non government institutions on the issues of adolescent health and development through advocacy workshops.
- Workshops to be organised to orient the service providers on AHD.
- Need to organise centre and state level advocacy workshops to bring awareness about the adolescent issues so as to bring in policy initiatives.
- Efforts to tap the print and the electronic media for advocacy for wider coverage.
- Provide counselling services to adolescents.

Note: The *intervention strategies* for addressing the issues of adolescent health and development, which have come up during the need assessment to be prepared by the partner NGOs for their area.

VII: Reccomendations For Project Implication

- Use of print and electronic media for knowledge and awareness is better and faster communication strategy in Jaipur and Varanasi.
- Strengthening the services at CHC and PHC level will have better utilisation as access to these services is better.
- Knowledge and awareness regarding puberty changes/adolescence are needed for both sexes with special emphasis on girls.
- Demystifying the myths surrounding menstruation and correct information on the issue is very important in all the areas. Same is for boys on the issues of adolescent reproductive biology in all the areas.
- On the issue of reproduction and sexual health, it is important to have a conducive environment in which, especially girls, can share their thoughts. The NGOs need to work very carefully. Involvement of communities is critical for sustainability of this effort to avoid any backlash. A very clear and open discussion needs to happen between MAMTA and NGOs' staff before taking it up. MAMTA needs to do close monitoring on this aspect for its outcome.
- This study reiterates that girls/women have been our prime targets for family planning services. It highlights the emphasis on men/boys involvement in sharing correct information on contraceptive basket with boys/men as much as with girls/ women. Different communication strategies have to be used in different areas.
- Intensive work has to be done with young boys and girls in all the districts regarding prevention of HIV/AIDS/STIs/RTIs. Here again, boys' involvement is as critical as of girls. But developing proper platform and a conducive environment is critical for its success for all the segments. A detailed long term plan for the same needs to be developed and closely monitored.
- An intensive input for sustaining girls and boys into school is an effective tool for enhancing marriage age of both boys and girls. For this, working with parents, communities and district officials is very crucial. Advocacy may help a lot in this aspect.
- Area specific interventions are needed with parents, key persons, especially religious leaders to enhance the status of girl child which, in turn, would have a reflection on her educational status and delayed age at marriage. Certain specific strategies need to be evolved for looking into social aspects like dowry and son preferences. Adult education input may also have influences on certain aspects of it.
- Along with sharing information and knowledge regarding early identification of illnesses, it is important to make services adolescent friendly in these areas. Orientation and discussion with the service providers and administration in the target area along with bringing adolescents and policy makers on a common platform, would help in this regard.
- Making young groups and activity plans for sustaining such groups for boys and girls is very important for open expression forums especially for girls. This could be an excellent forum for girl child and to a great extent for boys also to rent their feeling and emotions.
- Encouraging parent-child communication may enhance better understanding between parents and children. This will open another channel or source of information, which hopefully will be more correct, and socio-culturally appropriate.
- Information on risk of addiction and their potential life threatening outcome needs to be incorporated in their education programmes. Girls also need to be targeted for this.
- Gender equality needs to be very carefully and conspicuously built into various aspects of the intervention programme.
- The area wise prioritisation of issues need to be kept in mind while taking up the field activities although coverage on all aspects as decided during the group meetings, need to be developed as project grows with the community.

- The development aspects of adolescent needs like drinking water facility in Jodhpur and provision of high school needs to be taken up in real earnest to get total adolescent and community participation. This could be addressed through linkages and developing external resource support in the project. This needs to be closely monitored by MAMTA and if necessary, it will give required inputs to develop their strength/capacities in the organisation to undertake their issues. Similarly, issues of employment opportunities and skills need to be carefully looked into as per regional needs as seen in target areas of Uttar Pradesh.
- As issues unfold, there seems to be a definite demand for counselling centre in all the areas to address various myths and anxieties as seen on various issues like reproductive health, sexual health, employment and other behavioural aspects of adolescence. All four target areas should try to incorporate counselling centres in the existing service facilities available in the area.
- Parent-child communication as an issue is well highlighted by the parents. Hence working with parents to make them understand the needs of adolescents would be an appropriate entry point for the young people for information sharing and demystifying their myths.
- There is a good correlation between issues and concerns as raised by adolescents and the parents, validating the fact that adolescents do open up and understand their concerns given a non threatening environment.
- Since the public sector is accessible, it is a good strategy to work with all forms of service providers to upgrade their knowledge and awareness on issues of adolescent health. Yet, the image of the public sector is very poor in the eyes of the target population. Hence, there is bound to be continuous usage of private service providers for quite sometime. That is why it is very important to incorporate them in the sensitisation, awareness, and knowledge building workshops.

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Annexure

TABLES - Results and findings

Table 4 – Changes Perceived by Boys and Girls

	Rajasthan				Uttar Pradesh			
	Jodhpur		Jaipur		Varanasi		Mirzapur	
Changes Reported	**Boys/151***	**Girls/83***	**Boys/95***	**Girls/48***	**Boys/105***	**Girls/113***	**Boys/48***	**Girls/79***
Growth of pubic hair and on other parts of the body	47%	53%	59%	56%	20%	40%	21%	20%
Broadening of chest	40%	–	50%	–	60%	–	0	–
Pimples on face	12%	14%	13%	17%	60%	–	0	–
Change in voice	52%	23%	37%	25%	60%	–	0	–
Nocturnal emission	60%	–	61%	–	40%	–	60%	–
Masturbation	43%	–	54%	–	–	–	–	–
Development of sex organs	15%	14%	39%	43%	20%	–	21%	–
Attraction towards opposite sex	32%	59%	49%	29%	60%	60%	40%	0
Increase in body weight and height	65%	76%	64%	77%	100%	100%	100%	100%
Breast development	–	55%	–	73%	–	80%	–	39%
Conscious of their looks	8%	35%	29%	27%	20%	40%	0	0
Menarche	–	87%	–	87%	–	100%	–	100%
Become ambitious	55%	8%	40%	12%	20%	20%	0	0
Mood swings (agitated, irritable, depressed, like to play, go out)	60%	20%	22%	35%	–	60%	–	0
Girls capable of bearing child	36%	24%	55%	31%	–	–	–	–
Indulge in sexual relationship with CSW	10%	–	–	–	–	–	–	–
Start taking some form of addiction (tobacco,gutka etc.)	16%	–	20%	–	–	–	–	–

'–' not responded, '0' no information

* Total number of respondents

Table 5 – Menarche Management

Rajasthan		Uttar Pradesh	
Jodhpur (Girls)	Jaipur (Girls)	Mirzapur (Girls)	Varanasi (Girls)
Use cloth, reuse it after washing and drying it in shade, change it 2-3 times a day	Use cloth when flow is heavy, wash it, dry it in shade and re use it, change it 1-2 times in a day	Use clean cloth, wash and reuse	Use clean cloth and discard after one use
Some reuse cloth, change it 1-2 times a day, few discard it	Some do not use anything except under wear, others reuse cloth after washing and drying it in shade	Few respondents use cloth and reuse after washing.	Few respondents use cloth and reuse after washing.
Use sanitary napkin, change it 2-3 times a day, information about sanitary napkins from TV.	No information about menarche management though aware about it.	Use old cloth and reuse after washing	Use old cloth and discard after one use
Use sand in the cloth	Do not use anything in case of scanty flow	Use new cloths 3-4 times and then discard	Use sanitary napkins.
–	Use cloth, reuse it after washing it with soap and drying it in shade, change it 2-3 times a day	Some respondents use old cotton cloth a few times and then dump it in ground/burn.	–

Table 6 – Menarche: Myths, Misconceptions and Taboos

Rajasthan		Uttar Pradesh	
Jodhpur (Girls)	Jaipur (Girls)	Mirzapur (Girls)	Varanasi (Girls)
Cannot go to the temple	It is a dirty thing	Cannot go to the temple	Cannot go to the temple
No restrictions on cooking	Cannot go inside the kitchen	Can not work in the kitchen	Can not work in the kitchen
Entry into the kitchen prohibited but can cook if nobody else is there	Cannot go to the temple	Can not touch pickle	–
Food can be cooked by neighbour or procured from outside	Cannot pray (Namaz) at home (among muslim girls)	Entry in kitchen prohibited	Entry in kitchen and cooking is prohibited
Some have restrictions on taking bath	Working in kitchen prohibited	Some can not take bath or wash the head.	Some can not wash head
The girl is dirty during these days	Touching pickle and anything sour is not permitted	Some can not fetch water for drinking	–
Eat in separate utensils	Can cook after taking head bath on the 3rd day	Some can not serve food	–
–	–	It is a dirty period	Girls are impure during this period.
–	–	Mishap will occur if used cloth is thrown in the open	Food cooked by menstruating girl would get spoiled.
–	–	Touching a child during this period causes eye infection	–

Table 7 – Misconceptions About Nocturnal Emissions

Rajasthan		Uttar Pradesh	
Jodhpur (Boys)	Jaipur (Boys)	Mirzapur (Boys)	Varanasi (Boys)
Leads to weakness	Excessive nocturnal emission is a disease	It is a disease	It is a disease
It is a disease	Leads to weakness	Causes infertility	A cause for anxiety
Causes infertility	Laziness	Causes impotence	–
Sex organs become shapeless	Giddiness	Stop taking eggs	–
Mental disease and occurs when boys think a lot about girls.	Causes uneasiness	Leads to body pains, giddiness	–
Can cause STIs	Infertility	Weakness	–
Leads to early ejaculation	Because of this one is unable to satisfy his wife	Cause for lack of concentration	–
Causes impotence	Sex organs become deformed and dysfunctional	Makes you filthy	–
Excessive nocturnal emission is a disease	It is a bad habit, difficult to leave	Harmful for body and mind	–
Leads to body ache	Chances of being HIV infection increases	A cause for worry	–
It is a bad habit	Causes body ache	Raises doubts and confusion with no one to share	–
It is a sign of being fertile	Lack of concentration	Causes laziness	–
Causes Tuberculosis.	Frustration	–	–
Leads to breathlessness	Irritability	–	–
–	It happens because of body heat	–	–
–	Person becomes mentally weak	–	–
–	Urinating before sleep can prevent it	–	–
–	One can now get married	–	–

Table 8 – Sex and Sexuality - Perception of boys

Rajasthan		Uttar Pradesh	
Jodhpur (Boys)	Jaipur (Boys)	Varanasi (Boys)	Mirzapur (Boys)
Masturbation	Attraction towards opposite sex	Attraction to opposite sex	Attraction to opposite sex
Sex with animals	Masturbation	Masturbation	Fantasies and day dreaming
Desire for sex	Homosexuality	See blue films and sexy literature	Desire for marriage
Visiting prostitutes/CSW	Visiting prostitutes	Visiting prostitutes	–
Sex with another boy	Sex with animals	Sex with another boy	–
Information about sex and sexuality through films, books and friends	Desire for marriage	Sex with girl classmates, neighbouring girls	–
Attraction towards opposite sex	Desire for sex	Sexual fantasies	–
Sex with girls in the village	Information about sex and sexuality through films, TV and books	Sex with animals	–
–	Eve teasing	Sex is bad	–
–	Get excited on seeing sensuous things	–	–
–	Rape	–	–
–	Fantasies and day dreaming	–	–

Table 9 – Sex and Sexuality - Perception of Girls

Rajasthan		Uttar Pradesh	
Jodhpur (Girls)	Jaipur (Girls)	Varanasi (Girls)	Mirzapur (Girls)
Girls married as soon as menstruation occur or even before due to social pressure.	Girls married as soon as menstruation occurs.	Too many restrictions on movement and particularly talking to boys	Girls put under strict restrictions after attaining sexual maturity
Strict restrictions especially after attaining sexual maturity on movement and socialisation.	Too many restrictions on movement and particularly on talking to boys.	–	Girls married as soon as menstruation occurs, even before, for fear of some wrong steps she might take after sexual maturity.
Feel depressed because of suppression and restrictions.	Feel depressed because of suppression and excessive workload.	Feel depressed because of suppression	–
Attraction and fantasies towards opposite sex.	Attraction to opposite sex.	Fantasies and attraction towards opposite sex	–
Fantasies regarding married life.	Fantasies regarding opposite sex and married life	–	–
Desire to love someone.	Attraction to film heroes.	Desire to love someone.	–
Few talk to boys in Co-ed School.	No pre-marital relationship though heard of love and romance in school	Talk to boys in Co-ed School. No premarital relationship	–
Love and romance heard in school or on TV.	–	Love and romance heard in school	–
Attraction to film heroes	–	Attraction to film heroes	–
–	–	A girl eloped with a boy	–

Table 10 – Contraception Awareness Among Boys and Girls in the Two Districts and Sources of Information

	Rajasthan				Uttar Pradesh			
	Jodhpur		Jaipur		Varanasi		Mirzapur	
	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls
Contraceptive awareness	Incomplete knowledge of condoms, oral pills, vasectomy tubectomy and few had heard of Cu-T.	Incomplete knowledge of condoms, oral pills, Cu-T, injectables, vasectomy and Tubectomy.	Little knowledge on condoms, oral pills, Cu-T, vasectomy and Tubectomy	Limited information on Cu-T, condoms, oral pills, injectables, vasectomy and Tubectomy.	Aware of condoms but knowledge gaps	Knowledge of condoms, oral pills, sterilisation, Cu-T, injectables, vasectomy, Tubectomy.	No knowledge, Least interested to discuss.	Limited information about sterilisation, pills, abortion through tablets and home remedies.
	Though had little knowledge but were keen to control population growth	Knew that many women of the village were using spacing methods but had miscon-ceptions related to it.		Better knowledge among the married girls. Knew that many women are using spacing method. Many miscon-ceptions like vasectomy causes weakness in men.		They are too keen to limit the number of children. Therefore, well informed		Knowledge only among the married. Many miscon-ceptions, for example, pills cause madness.
Sources of information	Not known	TV, Health centre, School	Not known	TV, health centre, school books, women of the village	Not sure	TV. Health worker, ANM, NGO, School	–	Heard other people talking about it

Table 11 – Knowledge and Source of Knowledge on STIs/RTIs/HIV/AIDS

	Rajasthan				Uttar Pradesh			
	Jodhpur		Jaipur		Varanasi		Mirzapur	
	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls
STIs/RTIs	Not heard of STIs, do not have knowledge about it, educated boys of upper caste had information on it.	No knowledge of STIs, Many girls and women suffering from RTIs but not fully aware of it.	No knowledge on STIs, Few had heard of it but were not very clear about it.	Some had heard of STIs but did not have any knowledge on it, girls and women suffering from RTIs but not fully aware of it.	Awareness 40% Not even aware 60%	Only heard, not knowledge-able 60% (not heard of, nor aware 40%)	No knowledge	Some girls have RTI but seek no treatment 20% No knowledge 60% Only heard 20%
Source of Information on STIs/ RTIs	Not known	Not known	Not known	Some had heard of STIs from TV.	Not known	Not known	–	Not known
HIV/AIDS	Heard of AIDS but had incomplete information about it, few were aware of its prevention though had many miscon-ceptions related to it.	Heard of AIDS but do not have complete information on it (modes of spread and prevention), had miscon-ceptions and educated girls were better aware.	Incomplete information on AIDS.	Heard of AIDS but had incomplete information on it.	General awareness high Not aware of symptoms Not aware how HIV is sexually transmitted	Upper caste is well informed. Knowledge about spread and prevention 40% Misconce-ptions 20% (caused by touch, devil)	Awareness 20% Heard only 20% Neither aware nor heard 60%	Not aware 40% Not even heard 40% Heard but not clear 20%
Source of Information on HIV/ AIDS	Could not recall/TV	TV, school books, friends and sathin (grass root level workers of State Women and Child development Dept.)	Not known	TV, newspapers and books	TV	TV	Not known	TV

Table 12 – Age of Marriage of Boys and Girls

Rajasthan				Uttar Pradesh			
Jodhpur		Jaipur		Varanasi		Mirzapur	
Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls
Marriage age for boys is 15-20yrs	Though marriage age for girls is 18 yrs but are married off as early as 7-8 yrs or even before at times.	Marriage age of boys is usually 20-21yrs.	Marriage age usually 17-18 yrs but married off early as in one ceremony all sisters are married to save money.	18-22 Yrs. Among higher caste	16-20 Yrs (Gauna after 3-5 Yrs)	16-20 Yrs (Gauna practice Varies)	13-20 Yrs (Gauna after 4-5 Yrs. if marriage early)
Aware of legal age for marriage	Now parents do not want to marry their girls at 12-13yrs	In some places boys as young as 8-9yrs are also married off.	Girls are married off as early as 8-9 yrs.	12-13 Yrs (without Gauna)14-15 Yrs. (With Gauna), among lower caste	10-13 Yrs (Gauna after 3-5 Yrs)	–	11-15 Yrs (Gauna same time)
–	Muklawa is done after few years depending on the age of the boy and girl.	–	Av. Age in muslim community is 15-16 yrs. But are married even when they are just 8yrs. All sisters are married to save money.	15-18 Yrs, among other caste	12-14 Yrs (Gauna after 5-6 Yrs)	15-18 Yrs (Gauna Variable)	13-15 Yrs (Gauna simultan-eously)
–	In few places marriage age is 18-20 yrs	–	Muklawa is done 8-10 yrs later depending upon the age of the girl.	–		11-15 Yrs (gauna at the same time) Among 'Kol' community	11-15 Yrs (Gauna simultan-eously). Among 'Kol' community
–	At times Muklawa is done along with it.	–	Now a days educated parents do not marry their daughters till they are 18yrs.				

Table 13 – Socio-Cultural Determinants of Age at Marriage According to Gender

Rajasthan		Uttar Pradesh	
Boys	Girls	Boys	Girls

In case of boys no such determinants were reported during the group discussion	• Menarche signals marriage as she is considered grownup.
	• Social pressure (parents earn a bad name if daughter's marriage is delayed).
	• Parental imposition for marriage (girl neither consulted nor have a say)
	• Dowry (must for 'Rajputs' but necessary for a happy married life for other caste)
	• Gender discrimination (Girl considered a liability, thus should be married soon)
	• Educational status of the girl
	  • Early drop out due to early marriage
	  • more the education, later the marriage
	• Cultural stereotypes and practices according to caste affiliation.
	• Educational status of parentsPractices differ with caste and education
		• Social pressure (conventions)
		• Dowry (negotiating power in terms of education, occupation, income)
			• Social pressure (culturally determined conventional age of marriage, which if exceeded, calls for satire or even boycott or sanctions).
			• Menarche signals marriage for fear of girl going astray.
			• Parental imposition (girl not consulted)
			• Dowry (capacity to pay hastens or delays marriage)
			• Gender discrimination (Girls considered a liability, therefore sooner the redemption the better)
			• Cultural stereotypes and practices according to caste affiliation.
			• Educational status of the girl (more the education, later the marriage)
			• Girl is growing big is a concern for marriage.

Table 14 – General Health Problems Reported by Boys and Girls

	Rajasthan		Uttar Pradesh	
	Jodhpur	Jaipur	Varanasi	Mirzapur
Boys	• Malaria • **Cough, cold and fever** • Dermal disease • Jaundice • Renal problems • **General weakness** • **Tuberculosis** • Diarrhoea • Sexual diseases • **Eye infection** • Typhoid • **Giddiness**	• Malaria • **Weakness** • Stomach disorders • Headache • Giddiness • Jaundice • Hearing disorders • **Tuberculosis** • Sexual diseases • Cholera • **Eye infections**	• Fatigue and **weakness** • Stomach disorders • Deaf and dumb • Body pains • **Chest pain and cough** • Giddiness • Stunted growth • Headache • Ear pain and discharge • Intermittent fever • Myopia • Night blindness • Burning and blood in urine • Stammering	• **Weakness** • Stomach disorders • **Giddiness** • **Cough and chest pain** • Cholera • Stunted growth • Backache • Pneumonia • **Eye infection** • Headache • Hearing disorders • Night blindness • Epistaxis • Difficulty in urine
Girls	• RTIs • **Cough, cold** • Fever • Malaria • Menstruation related problems (heavy bleeding, pain in lower abdomen, backache, pain in legs) • Weakness • Pneumonia • **Tuberculosis**	• RTIs • Menstruation related problems • Fever • **Cough and Cold** • **Tuberculosis** • Jaundice • Cholera	• No priority to health • Menstruation related problems (heavy bleeding, pain in lower abdomen, backache, nausea, pain in legs) • **Weak eyesight, headache, fatigue, giddiness.** • one case of RTI/STI	• Two cases of RTI • Menstruation related problems

Table 15 – Emotional Problems Experienced by Adolescent Boys and Girls

	Rajasthan		Uttar Pradesh	
	Jodhpur	Jaipur	Varanasi	Mirzapur
Boys	• Insecure about their future • Irritability • **Anxious** to experiment (indulgence in addiction etc.) • Anxious to express sexual desires and agitated as unable to do so • Feel grown up but irritated as elders do not accept them as adults	• **Anxious** to experiment leading to risk taking behaviour and indulgence in addiction • Aggression due to elders **control** on their lives • Agitated as unable to express their sexual desires • Obsessed to achieve high set goals in life· Tensed due to realisation of responsibilities	• **Anxiety** and insecurity coupled with disillusionment about their future • Lack of concentration • Irritability	• Elders **control** their lives giving them a feeling of strangulation. • Oppressed due to the strong hold of higher caste landlords to whom they owe their survival • Feelings of inferiority • **Anxiety** and despair about their future • obsessed with the problems of survival, livelihood • lack of concentration
Girls	• Agitation and **depression** due to load of household chores • Feel shy in expressing desires • **Depression** due to parental pressure for marriage • Anger and **depression** due to mobility **restrictions** • **Restrictions** due to gender discrimination leading to rebellious nature	• **Depression** and anger towards parents due to work load • Shy in expressing their feelings • Irritable nature due to mobility **restrictions** • Agitation due to lack of decision making power regarding their marriage/education, leading to rebellious nature • **Depression** due to restrictions on seeking education • Angry on restrictions to socialise	• Too many **restrictions** on their movement make them irritable • **Depression** • Create their world of make believe as an escape from a life of oppression. • Agitation and helplessness due to lack of freedom to move out, to mix and to socialise.	• Too many **restrictions** leading to docility and submissiveness

Table 16 – Addictions Among Boys and Girls

	Rajasthan		Uttar Pradesh	
	Jodhpur	Jaipur	Varanasi	Mirzapur
Boys	Gutka (chewing tobacco), Ganja, Surti, alcohol, tablets	Smoking, tobacco chewing, Ganja, alcohol	Gutka (chewing tobacco),Ganja, Surti, Opium, Mendrex tablet, alcohol	Smoking, tobacco chewing, Ganja, alcohol
Girls	No addictions reported among adolescent girls	No addictions reported among adolescent girls	No addictions reported among adolescent girls, although smoking and tobacco chewing are common among women	No addictions reported among adolescent girls, although smoking and tobacco chewing are common among women

Table 17 – Gender Issues - Beliefs and Practices

	Rajasthan		Uttar Pradesh	
Issues	Jodhpur	Jaipur	Varanasi	Mirzapur
Education	Boys have the privilege of seeking education whereas there is social and parental pressure on girls to drop out.	Though girls are educated but are not encouraged to seek higher education.	Discrimination is less in the case of girls, although higher education remains the privilege of boys.	Girls enjoy much lower priority as compared to boys.
Food	No discrimination, although girls are the last to eat.	No discrimination reported though male members are served first.	No discrimination, although girls are the last to eat	No discriminations reported. Nonetheless, boys get better food and girls eat after everyone else has.
Freedom/ Independence	• Mobility restriction on girls. • Do not have any say in their marriage. • No decision making power.	• Restrictions on girl's movement • Restrictions on socialisation • Cannot decide for their marriage	• Strict restrictions on movement of girls. • No such restrictions for boys. Men folks take decisions for girls to follow	• Gender discrimination is a norm to be accepted, not to be questioned • Freedom is for boys
Attitudinal attributions	• Birth of male child celebrated	• Boys preferred over girls • Girls considered a burden/liability	• Birth of male child celebrated • Girls considered a burden	• Boys preferred over girls • Parents lenient with boys • Girls feel they have to lead a life of eternal servility
Dowry/ Marriage	• Dowry is rampant in the Rajput community. Though not demanded in the other castes but is customary. • Girls do not have any say in their marriage - whether it is selection of partner or age of marriage.	• Dowry though not rampant is given for a happy married life. Parents at times take loan for it. • Early marriage due to parental and social pressure. • Parental imposition.	• Dowry is a scourge haunting girl's parents, while it is considered as the legitimate expectation by the boy's parents • Girls do not have any say in their marriage - whether it is selection of partner or age of marriage.	• Dowry demand is rampant even if it means reeling under debt for the girls parents • Girls married early, since they are regarded as "others property"
Role obligations	Girls perform household chores while boys' role sphere is outside home.	Household responsibilities are on the girls but are hardly ever acknowledged	Girls supposed to take on responsibilities within the home while boys' role sphere is outside home.	Back breaking household responsibilities amounting to "servility". "Taken for granted" role which is hardly ever acknowledged.

Table 18A – Needs Identified by Adolescent Girls and their Prioritisation, Rajasthan

Rank 1	Rank 2	Rank 3	Rank 4	Rank 5	Rank 6	Rank 7
Jodhpur • Freedom from mobility restrictions	• Gender equality	• No early marriage	• Higher secondary school for girls should be within the village	• No restriction on talking to boys	• No restrictions on type of dress to wear	• Market should be within the village
Jaipur • No mobility restrictions • Burden of household work • Lack of education amongst villagers to understand the importance of education • No early marriage	• No family restrictions and pressure • Should be allowed to think for themselves • No time to play and study	• No decision making power·Mobility restrictions • Equal employment opportunities	• Lack of awareness among people to be broad minded· Should have a separate girls' school	• Should get employment after studies	• Should have a good secondary school in the village	–

Table 18B – Needs Identified by Adolescent Girls and their Prioritisation, UP

Rank 1	Rank 2	Rank 3	Rank 4	Rank 5	Rank 6	Rank 7	Rank 8	Rank 9	Rank 10
Mirzapur • Information on contraceptives • Freedom from parental restrictions • Education • Knowledge about STI/ AIDS. • Immunisation facility • No early marriage	• Reduce workload • Education	• Education (equality with boys) • No early marriage • Facilities for outdoor games	• Freedom from restrictions of in-laws • Health care facility	• Reduce workload • Marriage not a bondage					
Varanasi • Improve social status of girls • Freedom from parental restrictions • Independence • Education	• No early marriage • No dowry	• No discrimination on the basis of sex • No early pregnancy	• Education • No early pregnancy • Counselling for mental tension • No pressure to marry early.	• Freedom of mixing/ interaction with boys • Freedom of movement • Education • Freedom from pressure to marry • no eve-teasing	• Equal attention to likes and dislikes of girls • No dowry • Freedom to mix/interact with boys • Employment opportunities	• No restrictions at in-laws place • Attention to reproductive health problems particularly management of menstruation • Remove restrictions on socialising	Freedom of move-ment	No restrictions on type of dress to wear	Manag ement of menstr-uation

Table 19A – Needs Identified by Adolescent Boys and their Prioritisation, Rajasthan

Rank 1	Rank 2	Rank 3	Rank 4	Rank 5	Rank 6	Rank 7	Rank 8
Jodhpur							
• Water facility • Facility of tube-well • Availability of Sr. Secondary school • Knowledge and availability of nutritious food.	• Educational facility (availability of high school) • Health care facility • Facility of play ground • Promotion of health education	• Health care facility • Facility of high school • Employment opportunities • Recreational facility	• Telephone facility • Facility of roads in the village • Availability of government school • Employment opportunities • Opportunities for technical education	• Facility of roads in the village • Telephone facility • Facility for play ground	• Sports facility • Recreational facility • Facility of play ground		
Jaipur							
• Health care facility Knowledge to control population • Knowledge and availability of nutritious food • Facility for higher education • Employment opportunities	• Educational facility • Health care facility • Provision of coaching centre • Facility for higher education	• Facility to commute • Employment opportunities • Knowledge and availability of nutritious food • Provision of sanitation in the village	• Recreational facility • Drinking water facility • Contraceptive knowledge • Health care facility • Ban on child marriage	• Availability of post office • Poverty elevation • Library • Drinking water facility • Health care facility	• Telephone facility • Facility to commute • Provision of health club • Facility of play ground	• Library • Recreational facility	• Knowledge on STIs

Table 19B – Needs Identified By Adolescent Boys and Their Prioritisation, UP

Rank 1	Rank 2	Rank 3	Rank 4	Rank 5	Rank 6	Rank 7	Rank 8
Mirzapur • Employment opportunities • No early marriage. • Knowledge on health matters • Education and School facility	• Restoration of land grabbed by higher castes. • Freedom from addictions • Knowledge on AIDS • Employment opportunities • Accessibility to School	• Knowledge on adolescent issues • Refraining from commercial sex. • Proper growth (as against stunted growth) • Health facility	• Knowledge and awareness on health matters STI/AIDS • Treatment of health problems				
Varanasi • Treatment of health problems • Knowledge about AIDS • Proper growth (as against stunted growth) • Alleviation of poverty • Employment opportunities	• Protection from AIDS • Health care facility • Education • Counselling centre • Awareness about sex and sexuality.	• to be allowed to mix freely with girls • knowledge about biological changes during adolescence • Facility for higher education	• No early marriage • Health and fitness club • Health care facility	• Library	• Reduce the gap between family and the growing adolescent • Playground	• Music Club	• Pollution free environment

Table 20 – Parental Concerns for Boys (Triangulation) and their Prioritisation

Rajasthan		Uttar Pradesh	
Jodhpur	Jaipur	Mirzapur	Varanasi
• No facility for higher education • Poor knowledge on sex and sexuality and adolescent health • Poor knowledge of parents on sex and sexuality and adolescent health • No library • Poor employment opportunities • No provision of play ground • Poor nutritional status and lack of knowledge on it • No recreational facility • No sex education in schools • No qualified doctors for mental health problems • Communication gap between parents and their children • No proper health care facility • No counselling facility	• Poor nutritional status and lack of knowledge on it • No facility for higher education • Early marriage • No provision of health club • Poor knowledge on sex and sexuality and adolescent health • Poor employment opportunities • No proper health care facility • No provision of play ground • Poor sanitation • No library • Exposure to media (adult films, magazines etc.) before age • Polluted environment • Prevalence of general health problems • Addiction • Poor contraceptive knowledge • Lack of proper guidance • Irresponsible behaviour	• Unemployment • Fear of their boys going astray • Addictions • Apprehensive of their boys visiting prostitutes • Lack of education • Strict control • STD awareness • Prospects of boys going astray • Drinking and substance abuse • No appreciation of adolescent problems • Knowledge of contraceptives lacking • Loss of values • No occupational capabilities • Awareness • Lacking about harmful effects of substance/ drug abuse • Poverty • Attraction between boys and girls and instances of elopement	• Health problems among their wards • Unemployment • Stunted growth of their boys • Counselling needed in sex and sexuality as also adolescent problems • Lack of education • Access to health services • Boys not interested in studies • High rate of substance/ drug abuse • Absence of health club • Gap between elders and adolescents • Poverty • Lack of knowledge about changes during adolescence • Separate school for girls • Addictions • Illiteracy • Tendency to Quarrel • Sexual indulgence suspected. • Lack of sanitation • Immoral sexual tendencies • Boys staying away from home • Angry and Disobedient • Boys look worried and absent minded • Craze for films • Lack of environmental and intellectual stimulation

Table 21 – Parental Concerns about Adolescent Girls (Triangulation)

Rajasthan		Uttar Pradesh	
Jodhpur	Jaipur	Mirzapur	Varanasi
• Knowledge about contraceptives lacking • Gender bias • Communication gap between mothers and daughters • Poor educational status • Poor knowledge on pregnancy, delivery, ANC and Post natal care • Early marriage and early pregnancy • Ignorance about RTIs/ STIs HIV/AIDS • RTIs left untreated or have home remedies for it • Excessive work load • Rebellious due to oppression • Incomplete information and misconceptions related to menarche management.	• Gender bias • Early marriage and early pregnancy • No say in her marriage • No widow remarriage • Poor knowledge on RTIs/ STIs/HIV/AIDS • Early marriage and early pregnancy • Poor knowledge on pregnancy, delivery, ANC and Post natal care • Need for education • Poor information on menarche and its management • Poor nutritional status • Dowry • RTI left untreated • No decision making power • Knowledge about contraceptives lacking	• Knowledge about contraceptives lacking • Lack of education • Early marriage and early pregnancy • Ignorance about RTI/STI/ AIDS • RTI left untreated • Dowry • Gender bias, particularly in education of girls	• Information on menarche and its management • Dowry • Early marriage and early pregnancy • RTI left untreated • Need for education • Knowledge about AIDS • Premarital sex (boys involved) • Gender bias • No appreciation for the many chores women have to perform • Incidence of infertility • Economic dependence on male members • Lack of opportunities for earning livelihood. • Need for income generation programmes.

Matrix 1 – Treatment Seeking Behaviour of Boys - Jodhpur District, Rajasthan

Health Service	Criteria Underlying Choice				
	Unaware of other services	Locally available	Acute disease	Less expensive	Emergency
Witchcraft	2	2	5	2	–
Quacks	3	1	5	1	2
Government Dispensary	4	–	1	3	3
Household Remedies	3	–	–	–	3
Private Qualified Doctors	-	–	1	4	3

*Rating Assigned (1 = Most Preferred 5 = Least Preferred)

Matrix 2 – Treatment Seeking Behaviour of Girls - Jodhpur District, Rajasthan

Health Service	Criteria Underlying Choice				
	Good Treatment	Locally available	Acute disease	Less expensive	Trust
Witchcraft	2	1	4	2	1
Quacks	2	2	5	3	3
Government Dispensary	2	4	1	2	3
Household Remedies	–	2	–	2	–
Private Qualified Doctors	2	3	2	4	2

*Rating Assigned (1 = Most Preferred 5 = Least Preferred)

Matrix 3 – Treatment Seeking Behaviour of Boys - Jaipur District, Rajasthan

Health Service	Criteria Underlying Choice				
	Unaware of other services	Locally available	Acute disease	Less expensive	Emergency
Ojhas	–	2	3	2	2
Quacks	2	2	4	1	3
Government Dispensary	–	3	1	2	2
Household Remedies	–	3	4	2	2
Private Qualified Doctors	2	–	3	–	2

*Rating Assigned (1 = Most Preferred 5 = Least Preferred)

Matrix 4 – Treatment Seeking Behaviour of Girls - Jaipur District, Rajasthan

Health Service	Criteria Underlying Choice				
	Good Treatment	Locally available	Acute disease	Less expensive	Trust
Witchcraft	2	2	4	2	1
Quacks	3	2	4	2	2
Government Dispensary	2	3	1	2	3
Household Remedies	4	5	5	2	3
Private Qualified Doctors	2	3	2	4	3

*Rating Assigned (1 = Most Preferred 5 = Least Preferred)

Matrix 5 – Treatment Seeking Behaviour of Boys and Girls - Mirzapur District, UP

Health Service	Criteria Underlying Choice				
	Good Treatment	Less Expensive	Locally available	Trust	Medicine Given
Witchcraft	4	2	1	3	5
Quacks	2	3	5	2	2
Government Dispensary	2	4	5	–	4
Household Remedies	5	2	1	4	5
Private Qualified Doctors	3	5	5	3	3

*Rating Assigned (1 = Most Preferred, 5 = Least Preferred)

Matrix 6 – Treatment Seeking Behaviour of Boys and Girls - Varanasi District, UP

Health Service	Criteria Underlying Choice					
	Unfavourable Experience	Emergency only	Faith	Elders Pressure	Desperation	Accessible
**Rest	5	5	1	3	–	–
**Disease will automatically go	3	–	1	2	–	–
Block Hospital	1	2	5	–	3	5
Quack	5	–	1	5	–	1
Ojha	5	–	1	1	2	2
Qualified Doctor	2	2	–	–	4	5
Household Remedies	5	–	–	1	5	1
District Hospital	2	1	–	–	1	5

*Rating Assigned (1 = Most Preferred, 5 = Least Preferred)

** Don't seek any service

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